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ABSTRACT

This compilation on assistive technology devices and services aims to improve understanding of funding streams and creative ways to eliminate funding barriers in Medicaid, special education, and vocational rehabilitation. The first part comprises a workbook titled "A Road Map to Funding Sources." It assists in creating a systematic approach to identifying public and private funding streams for assistive technology in a state. It attempts to identify entry points for a particular funding source, bridges to other funding options, and ways to avoid detours and stop signs that delay or deny reimbursement for assistive technology. Following discussions of the major financial assistance systems and their values, the workbook outlines 14 problem-solving challenges to expand understanding of what is possible with public and private funding. These challenges address the areas of interagency coordination, agency responsibility, private insurance, and others. The workbook also provides excerpts from relevant federal regulations and data on state allotments for assistive technology projects. The second part, "Outline of Federal Laws and Rules," describes specific sections of federal laws and rules relating to the Medicaid program, special education (including early intervention), and vocational rehabilitation (including supported employment) that are resources for assistive technology funding. This information covers mandatory and optional services, statutory and regulatory terms, program criteria supporting funding, program criteria serving as funding barriers, and eligibility criteria. (JDD)

RESNA
TECHNICAL ASSISTANCE
PROJECT

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ASSISTIVE TECHNOLOGY: A FUNDING WORKBOOK

PART I. *A Road Map To Funding Sources*
PART II. *An Outline Of Federal Laws And Rules*

RESNA PRESS

RESNA
1101 Connecticut Avenue, N.W.
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Washington, DC 20036
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ASSISTIVE TECHNOLOGY: A FUNDING WORKBOOK
1991 Edition

developed by:
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Cover designed by: Karen L. Moore. The three ring binder was provided so that pertinent information about funding for assistive technology services and devices could be added.

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ACKNOWLEDGEMENTS

When Congress passed the *Technology-Related Assistance for Individuals with Disabilities Act of 1988 (P.L. 100-407)*, it recognized that assistive technology devices and services can enable persons with disabilities to become more independent, productive and integrated members of society. Sadly, though, many individuals who could benefit from available assistive technology do not have access to it because some consumers, family members, professionals and state agency personnel do not fully understand federal funding streams available for assistive technology services. These individuals also may lack the knowledge of how to work within their state agencies to access these services.

Development of this publication resulted from technical assistance requests by "Tech Act" funded state personnel. It is our hope that this publication will facilitate a better understanding of funding streams and creative ways to eliminate current funding barriers in Medicaid, special education and vocational rehabilitation.

The RESNA TA staff and our consultants found creating this publication an exciting adventure. We learned a great deal about funding for assistive technology services. Most fascinating has been the advances made at both the federal and state levels resulting in increased funding for assistive technology services since we started working on this publication a year ago. These strides include the new policy directives from the Department of Education in vocational rehabilitation and special education services and court decisions, such as the ones in New York and Oregon, which came about only due to the efforts of consumers and advocates. It is our hope that this publication will help more individuals to become part of this exciting system change process occuring nationwide.

Many thanks to the authors, Michael Morris and Lewis Golinker, for sharing their vision and expertise in system change and funding for assistive technology services. Without them this publication would never have come to fruition. Thanks also to Carol Cohen, Project Officer, and staff at the National Institute on Disability and Rehabilitation Research for their continued support for the work at the TA project. Thanks is a small word for the big job done by Karen L. Moore, Project Assistant, who had the patience and sense of humor to work through the many edits and changes to make this publication readable. Nell Bailey, Project Associate, deserves a special thanks for her time and effort in coordinating the production and editing of this book. And finally, my deepest appreciation to the State Directors and staff for their inquiries which sparked the idea and creation of this book and for their patience in receiving it.

Karen Franklin, Project Manager
RESNA Technical Assistance Project

RESNA
TECHNICAL ASSISTANCE
PROJECT

A ROAD MAP TO FUNDING SOURCES

JANUARY 1991

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A ROAD MAP TO FUNDING SOURCES

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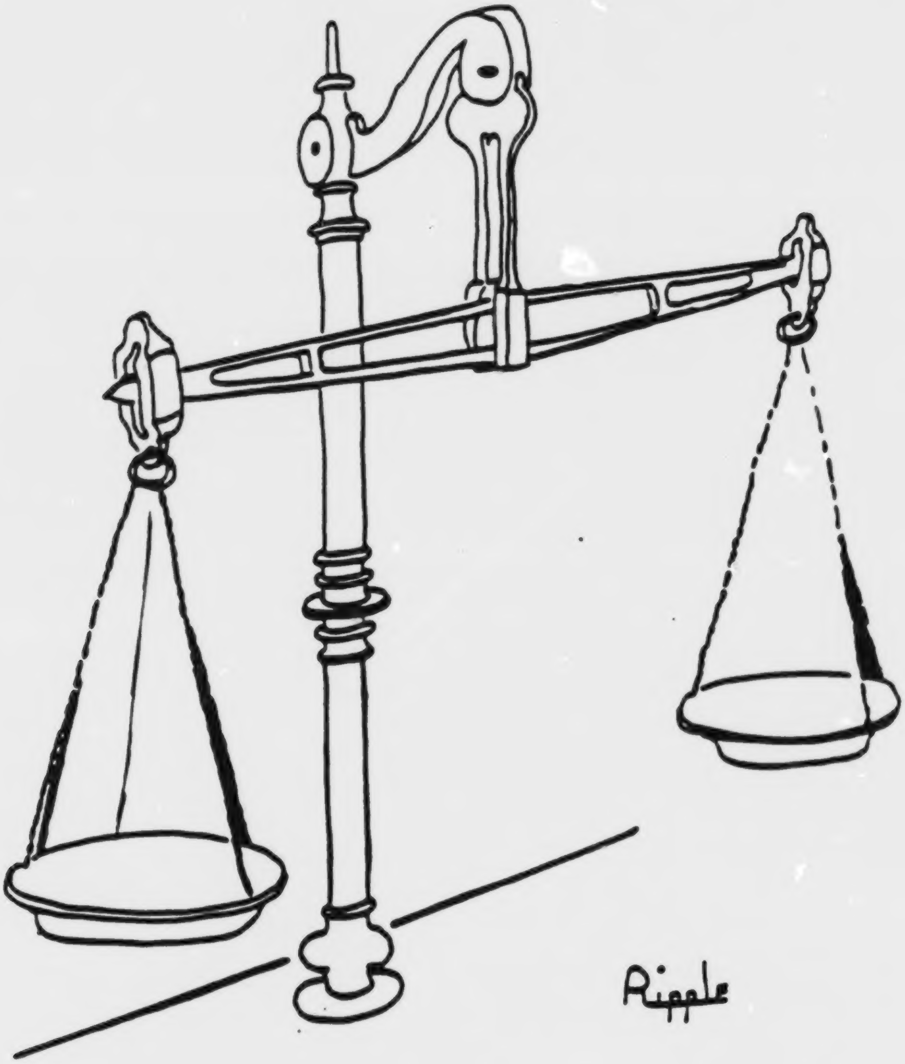
ASSISTIVE TECHNOLOGY
FUNDING
A USER FRIENDLY WORKBOOK



BALANCING COMPETING INTERESTS

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PART I

INTRODUCTION

I. Introduction

Assistive Technology is redefining what is possible for children and adults with a wide range of cognitive and physical disabilities. In the home, the classroom, the workplace, and the community, assistive technology is providing creative solutions that enable individuals with disabilities to be more independent, self-confident, productive, and integrated into the mainstream.

Assistive technology is adapted toys, computers, seating systems, powered mobility, augmentative communication devices, special switches, and thousands of commercially available or adapted solutions to improve an individual's ability to learn, compete, work, and interact with family and friends.

In every state children and adults with disabilities are searching for assistive technology solutions that will respond to individualized needs and enhance independence. Interviews with parents, individuals with disabilities, and professionals across the country remind us that the major problem we face today is not primarily the research and development of new technologies, but instead the linking of already existing assistive technology solutions to the problems faced by persons with disabilities as they learn and engage in daily living activities.

With the passage of the Technology-related Assistance Act (P.L. 100-407) in 1988, children and adults with disabilities have a new set of expectations about assistive technology service delivery that is more available, accessible, and responsive to consumer needs. In every state parents and professionals are still learning about and refining "best practices" in the delivery of technology-related assistance. There is no one, definitive model or exemplary program that can or should be copied as states attempt to meet their new mandate.

Increased awareness of what is possible and the delivery of services in a multidisciplinary approach, will enable individuals with disabilities to be part of the decisionmaking team to identify the most appropriate technology to enhance function. Assistive technology is a means to rather than an end in itself. Adapted switches to activate a toy is a means to more independent play, gaining an understanding of cause and effect, and expanded social interaction with other children and family members. An adapted keyboard, a computer, and an augmentative communication device is a means to compete in the work force. Through experience we have learned assistive technology is more than an adaptive device or special equipment. Assistive technology application involves awareness, assessment, identification of appropriate solutions, training, practice, skilled professionals from multiple disciplines, follow up support and maintenance. What will make assistive technology devices and services possible for you on an individual level, on a local service agency level, and on a systems basis? The obvious answer is funding.

What is not so obvious is where do I go to secure funding. This workbook is a first effort at increasing awareness and understanding of what might be possible with state and federal public funding streams. There is no single answer to solving the assistive technology funding problems in your state. No two states will develop funding solutions on an individual or systems level that are identical. What this workbook will assist you to do is create a road map for your state. The key markers to be identified are public and private funding streams. The challenge we share is to clearly identify the entry points for a particular funding source, bridges to other funding options, and ways to avoid detours and stop signs that delay or deny reimbursement for assistive technology.

Unlike the typical road map, this one may need updating several times a year, as we collectively work on changing regulations, amending state plans, refining interagency agreements, developing new policies and procedures, and finally revising day-to-day practices as it affects the individual technology user. To develop the comprehensive road map for your state, will require the involvement of all potential stakeholders including individuals with disabilities, parents, providers, professionals, technology manufacturers and dealers, and state agency officials.

As a final thought, you probably remember the classic children's tale of Alice in Wonderland.

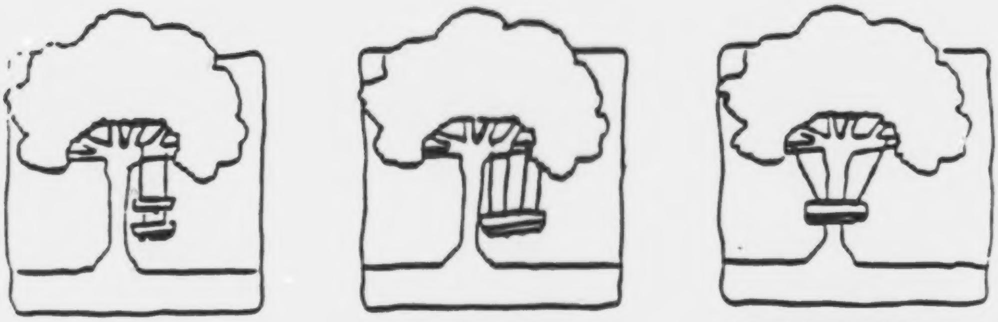
> "You may recall that Alice, in the very earliest stages of her adventures in Wonderland, came upon an extremely small entrance to a very lovely garden. How she longed to get out of the dark hall and wander about, among these beds of bright flowers and cool fountains yet, she could not even get her head through that doorway. What poor Alice had to do to enter that garden was truly a distracting experience of potions and cakes and telescopes and tears."

There is a parallel between Alice's adventure and the search now going on by thousands of persons with disabilities and their families for assistive technology funding.[1] (Testimony by Mary Ann Carrol, UCP of New York City before the House Select Education Committee on May 10, 1988.) The possibilities of greater independence through technology are within reach but too often inaccessible because of the tortuous unmarked path to funding. The mandate of P.L. 100-407, the Technology-related Assistance Act is to establish a road map that is easy to follow for the potential technology user.

PART II

UNDERSTANDING THE SYSTEM

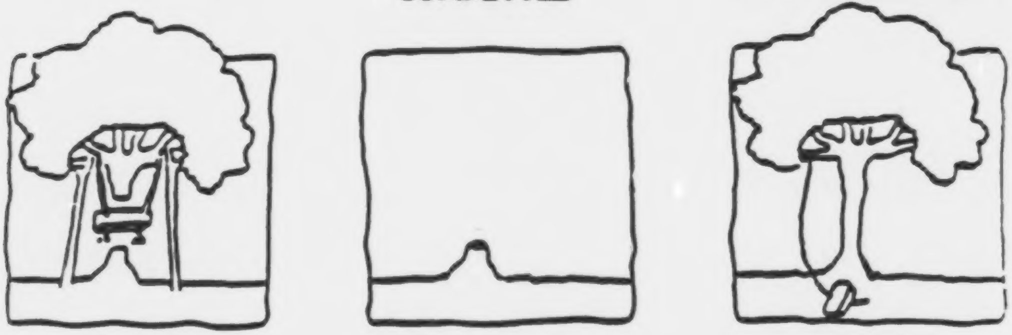
HOW A BILL BECOMES A LAW



AS INTRODUCED

AS AMENDED IN COMMITTEE

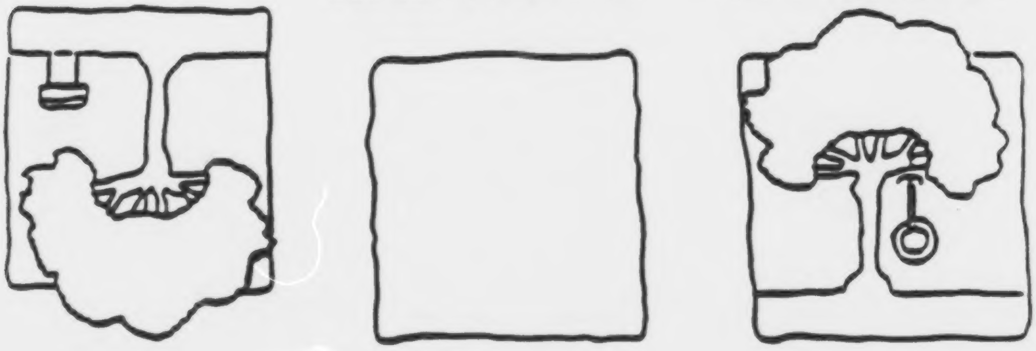
AS AMENDED ON SECOND READING



AS ENACTED

AS FUNDED BY JOINT BUDGET COMMITTEE

AS IMPLEMENTED BY THE STATE AGENCY



AS REPORTED BY THE MEDIA

AS UNDERSTOOD BY THE PUBLIC

WHAT WAS ACTUALLY NEEDED

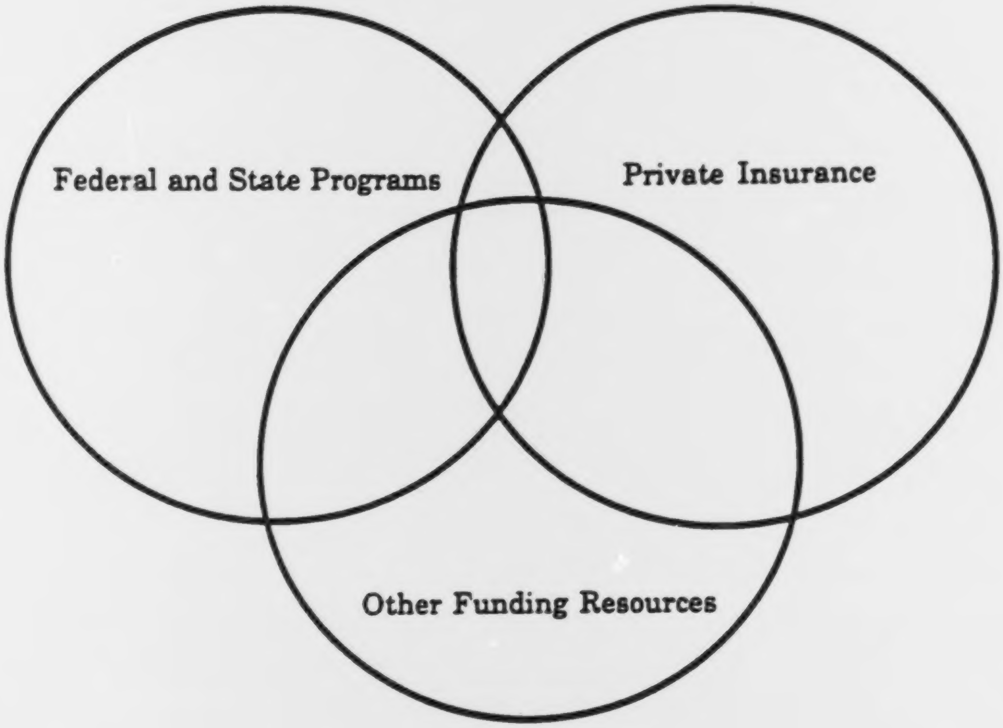
Unfortunately, we do not know who created this cartoon.

II. Understanding the System

> "We believe equal opportunity, equal access, and greater economic independence must be more than slogans ... We must encourage the provision of rehabilitation and other comprehensive services orientated toward independence within the context of family and community. For only through opportunities to use the full range of potential will our disabled citizens attain the independence and dignity that are their due."
>
> President Ronald Reagan,
> November, 1983

Most individuals with disabilities and families with children who have significant disabilities cannot afford to purchase assistive technology devices and services they need. There are three major systems an individual or family may look to for financial assistance: federal-state government funded programs, private insurance, or nonprofit agencies with a mix of public-private support.

Funding Sources


Federal and State Programs
Private Insurance
Other Funding Resources

FUNDING ROADBLOCKS

Lack of coordination

Multiple funding sources

Finding the true payor

Learning who makes funding decisions

Discovering the factors in funding decisions

The focus of this workbook will be on state-federal government funded programs and the necessities of coordination with the other two systems. The choice of this approach should not imply less interest or importance of the other two systems. The coordination of public, private, and public-private partnerships in terms of financial resources remains a very important goal. However, what is most possible through the state coordinating task forces established as a result of P.L. 100-407 is a re-examination of funding policies within state-federal government funded programs. The key stakeholders involved in implementing P.L. 100-407 have the authority to make policy changes that will substantially improve the public funding picture. Any policy changes made in the public system will drive changes in the other two systems.

In the past twenty-five years, Congress has established over thirty (30) programs that affect Americans with disabilities. There are over a dozen (12) agencies on the federal level charged with the responsibility of managing these programs, interpreting Congressional mandates, and monitoring state implementation. Although sometimes described as a patchwork quilt of existing policies and programs, federal support for individuals with disabilities continues to grow and becomes more complex each year.

It is easy to become intimidated by the complexity and fragmentation of interests. However, it is important to realize that the variety of program options provide the technology user with multiple opportunities for funding and reimbursement. If together we draw the road map, we can learn how to master the financial maze of diverse federal mandates.

STEP ONE - UNDERSTANDING STATE-FEDERAL RELATIONSHIPS

It is important to understand how government operates on a federal level and the critical relationship between the federal and state levels of government.

CONGRESS

↓

DESIGNATED FEDERAL AGENCY

↓

STATE AGENCY

↓

LOCAL SERVICE AGENCIES

↓

INDIVIDUALS WITH DISABILITIES

Note: A state receives Federal dollars conditioned by assurances to comply with federal program mandates - that define eligibility, scope of services, individual program planning, procedural safeguards, and complaint resolution.

Types of Federal Programs

There are three basic types of federal programs. The majority of federal assistance flows to a state based on submission and approval of a state plan. A second type of assistance is received directly by individuals. A third type of assistance is received directly by a state, a nonprofit agency, a university, or any nonprofit entity such as a school district as a result of responding and competing successfully with a grant application to a federal request for proposals on a specific subject priority.

PROGRAMS THAT BENEFIT PERSONS WITH DISABILITIES
(FISCAL YEAR 1989)

		$12.5	billion
1.	Supplemental Security Income (SSI)	$23.5	billion
2.	Social Security Disability Insurance (SSDI)	$34	billion
3.	Medicaid	$92	billion
4.	Medicare		
5.	Education of Handicapped Children Act	$1.5	billion
	(Part B - P.L. 94-142)		
6.	Vocational Rehabilitation	$1.5	billion
	(Title I - Basic State Grant)		
7.	Early Intervention	$80	million
	(Basic State Grants - Part H P.L. 99-457)		
8.	Developmental Disabilities	$61	million
	Basic State Grant		
9.	Developmental Disability (DD)	$21	million
	Protection and Advocacy Systems	$13	million
10.	DD University-Affiliated Programs	$2.7	billion
11.	Title XX Social Service Block Grant	$553	million
12.	Maternal and Child Health Block Grant	$26	million
13.	Centers For Independent Living		
14.	Comprehensive Services for Independent Living	$13	million
	Part A		
15.	Technology-Related Assistance Grants	$15	million
	P.L. 100-407	$1.8	billion
16.	Job Training Partnership Act	$18.7	million
17.	Projects With Industry		
18.	National Institute on Disability and	$54.3	million
	Rehabilitation Research	$2.6	million
19.	Special Recreation Programs	$8	million
20.	Transition and Secondary Education Programs		
21.	State Operated Programs - Special Education	$146.4	million
	P.L. 89-313	$251.5	million
22.	Preschool Education Grants	$5.8	million
23.	Severely Handicapped Demonstration Projects	$850	million
24.	Vocational Education	$442.9	million
25.	National Institute of Child Health and Human Development	$27	million
26.	Rehabilitation Demonstration Projects	$27.6	million
27.	Supported Employment State Grants	$5.4	million
28.	Special Education Technology Grants	$6.5	million
29.	Postsecondary Education Demonstration Grants	$23.7	million
30.	Early Education Demonstration Grants	$1.4	billion
31.	Head Start	$34.9	million
32.	UMTA Vehicle Purchase 16(b)(2) Program Grants		
33.	Housing Development Loan Program	$480	million
	Section 202	$5.9	million
34.	Independent Living for Older Blind Individuals		

NOTE: Access to these federal programs may be by the individual by applying directly to a branch office of a federal agency (local social security office, SSI or SSDI) or indirectly by the individual through state and local agencies (public school, state rehabilitation offices, and private non-profit agencies) who provide services based on grants or contracts with local, state and federal government agencies.

Not all of the federal programs listed are exclusively for individuals with disabilities. Each program has specific requirements regarding eligibility for services. Factors considered include:

- age
- level and type of disability
- educational performance
- employment potential
- functional skill levels
- income level of individual or family

FEDERAL AGENCIES OF IMPORTANCE TO PERSONS WITH DISABILITIES

Office of Special Education Programs
330 C Street, SW
Washington, DC 20202-2736
(202) 732-1007

Rehabilitative Services Administration
Department of Education
330 C Street, SW, Rm. 3028, Switzer Bldg.
Washington, DC 20202-2531
(202) 732-1282

Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235
(301) 965-0486

Administration on Developmental Disabilities
OHDS
200 Independence Avenue, SW
Room 356-D, HHH Building
Washington, DC 20201
(202) 245-2890

Health Care Financing Administration
Public Information
Hubert H. Humphrey Building
300 Independence Avenue, SW
Room 4248
Washington, DC 20201
(202) 245-6113

Office of Maternal and Child Health
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2350

National Institute on Disability and Rehabilitation Research
Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-2645
(202) 732-5066

National Institute of Child Health and Human Development
Office of Research Reporting
Bldg. 31, Rm. 2A 32
Bethesda, MD 20892
(301) 496-5133

National Institute on Deafness and Other Communication Disorders
National Institute of Health
9000 Rockville Pike, Bldg. 31A, Room 1B62
Bethesda, MD 20892
(301) 496-7243

National Institute of Mental Health
Public Inquiries Section
5600 Fishers Lane, Room 15C-05
Rockville, MD 20857
(301) 443-4513

National Institute of Neurological Disorders
National Institute of Health
9000 Rockville Pike, Bldg. 31A, Room 8A/06
Bethesda, MD 20892
(301) 496-5751

Head Start
ACYF
330 C Street, SW, Room 2310-B
Washington, DC 20202
(202) 245-0562

Office of Human Development Services
Department of Health and Human Services
200 Independence Ave., SW, Room 724-F
Washington, DC 20201-0001
(202) 755-4560

Architectural and Transportation Barriers Compliance Board
1111 18th Street, NW
Suite 501
Washington, DC 20036
(202) 653-7834

National Council on Disability
800 Independence Avenue, SW
Suite 814
Washington, DC 20591
(202) 267-3846

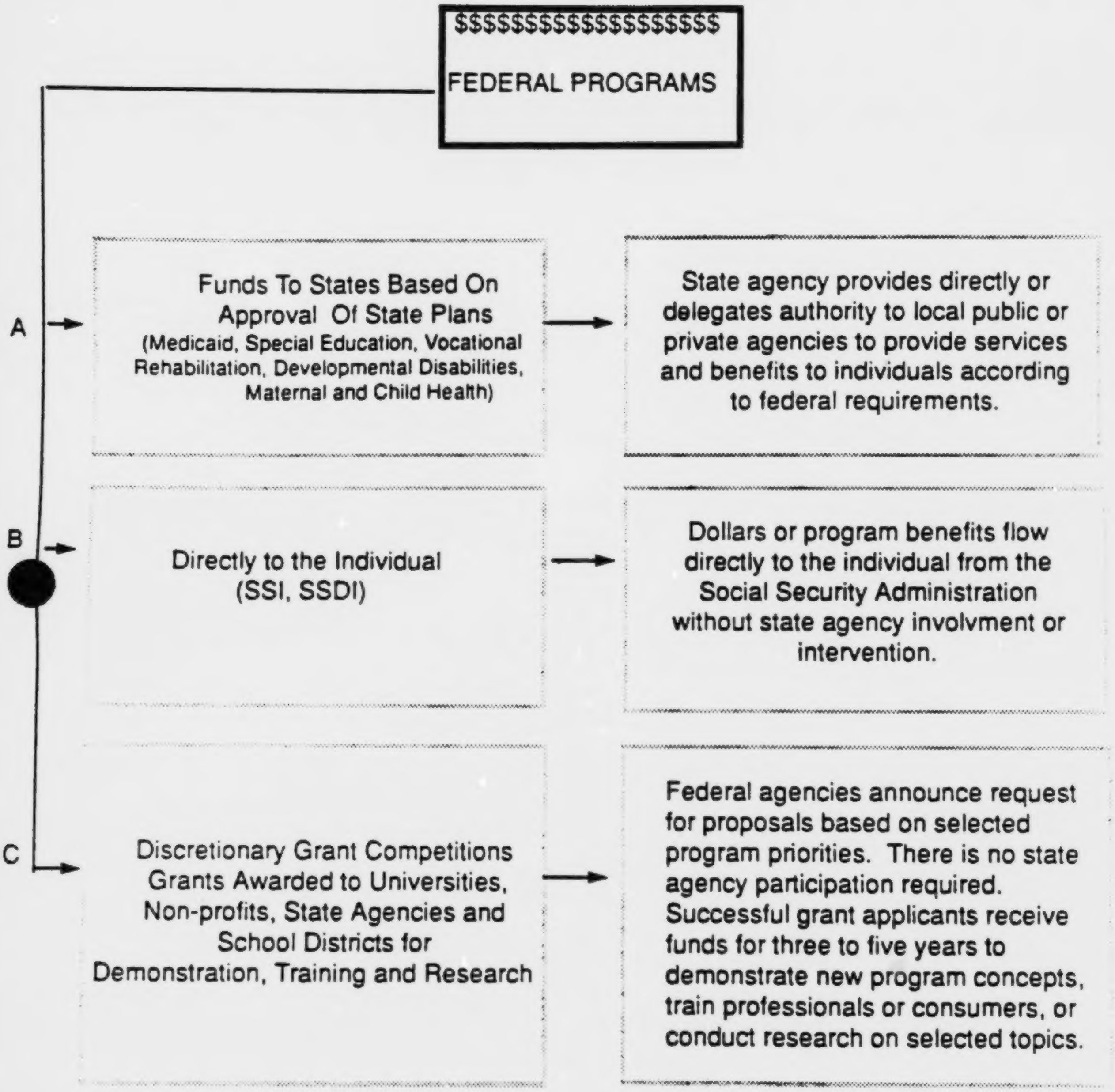
President's Committee on Employment of Persons With Disabilities
1111 20th Street, NW
Suite 636
Washington, DC 20036-3470
(202) 653-5044

President's Committee on Mental Retardation
North Building, Room 4057
330 Independence Avenue, SW
Washington, DC 20201
(202) 245-7634

Department of Housing and Urban Development
Section 202- Fair Housing and Equal Opportunity Office
451 7th Street, SW
Washington, DC 20410
(202) 708-3735

U.S. Administration on Aging
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201
(202) 245-0641

THREE TYPES OF FEDERAL PROGRAMS



Funds To States Based On Approval Of State Plans (Medicaid, Special Education, Vocational Rehabilitation, Developmental Disabilities, Maternal and Child Health)

State agency provides directly or delegates authority to local public or private agencies to provide services and benefits to individuals according to federal requirements.

Directly to the Individual (SSI, SSDI)

Dollars or program benefits flow directly to the individual from the Social Security Administration without state agency involvment or intervention.

Discretionary Grant Competitions Grants Awarded to Universities, Non-profits, State Agencies and School Districts for Demonstration, Training and Research

Federal agencies announce request for proposals based on selected program priorities. There is no state agency participation required. Successful grant applicants receive funds for three to five years to demonstrate new program concepts, train professionals or consumers, or conduct research on selected topics.

STEP TWO - UNDERSTANDING STATE PLANS

Most federal laws that direct funds be expended require a state to submit a state plan for approval by the assigned federal agency. Each federal law will list requirements to be met by the state and to be described in the state plan. A typical list of requirements include the following:

1) designate the state agency to administer the plan;
2) describe the scope of services to be provided;
3) describe service goals and priorities;
4) provide assurances that individual program planning and meeting requirements are met;
5) provide for financial participation by the state; and
6) provide assurances that procedural safeguards and an appeal process as required by law will be implemented.

It is most important we gain an understanding and appreciation of:

A) What the law and regulations require at both the federal and state level. (To receive funds, a state must provide certain services and follow specific procedures);
B) What choices a state may have as prescribed by law and regulations (A state selects from a menu of service options, and who will be eligible for services); and
C) What is not required by law or regulation, but has become a custom or practice in a state based on decisions made by the lead state agency.

THE A,B,C 'S OF POSSIBILITIES

A. LAW AND REGULATIONS
MUST BE DONE

As a condition of receipt of federal funds, states must comply with federal program requirements. Failure to comply is an enforcement issue that should be the responsibility of the designated federal agency.

B. LAW AND REGULATION
STATE HAS CHOICES

As a condition of receipt of federal funds, a state has discretion to choose from a menu of program choices and must indicate them in their state plan. Expanding state plan options should be a focus of advocacy (i.e., in Medicaid the inclusion of such optional services as speech and physical therapy).

C. CUSTOM AND CURRENT
PRACTICES

Problems with accessing services or the scope of coverage may not be a problem of federal law or regulation. It may be state policy or practice. The focus of advocacy should then be on state government not the Congress or the designated federal agency.

WHEN YOU ARE TOLD NO

YOU SHOULD RESPOND:

IS IT A LAW?

IS IT A STATE POLICY?

IS IT SIMPLY CUSTOM OR LOCAL CURRENT PRACTICE?

Consumer interest, expectation and advocacy when organized can change laws, policies, and practices. There are different approaches for changing a current practice or policy. A director or supervisor may have the authority to do so at a local or state level. Changing laws or regulations will take more time and need the support of many individuals and groups with similar interests. It is simple to blame the federal government for all problems. Some problems will be appropriately resolved at a local or state level.

PART III

VALUES

BEST FOOT

FORWARD

BEST FOOT FORWARD

Values

Assistive technology is more than a means to improve function. As a means to enhance mobility, communication, learning, productivity, and independence, assistive technology can open the doors of community life to people with disabilities.

Integration should not be considered an unusual experience or some type of demonstration project. It is not something you earn or prepare for. We should not ask the question why or when. The question we must answer is how to make integration work in our schools, in the work place, and in neighborhoods. Technology can be the great enabler and equalizer of opportunity. Technology can help bring together children with and without disabilities to share social and educational experiences.

It would be a tremendous waste of resources to identify ways assistive technology can help a child to communicate or learn in a separate school without further examining approaches to supporting a child in a regular classroom environment. It would be of similar concern in a time of limited or finite resources to focus technology creative problem solving ability on finding ways for individuals in a sheltered work environment to be more productive when there are diverse opportunities for work site adaptations and accommodations in an integrated competitive work environment.

Integration tools for individuals with severe disabilities may include:

- motorized wheelchairs
- communication devices with voice outputs
- computer learning or work stations
- velcro
- adjusting the height of desks or tables
- adapted switches
- software
- printers
- screen reading device with voice output
- environmental control devices
- adapted writing instruments
- adapted eating utensils

Although there are still conflicting goals that drive some federal funding streams, the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 100-146) articulates what has become a nationwide consensus viewpoint of what should be our goals for all persons with disabilities:

Independence
Productivity
Integration

The term "independence" means the extent to which persons with disabilities exert control and choice over their own lives.

The term "productivity" means-
"(A) engagement in income-producing work by a person with disabilities which is measured through improvements in income level, employment status, or job advancement, or
"(B) engagement by a person with disabilities in work which contributes to a household or community.

The term "integration" means-
"(A) the - (i) use by persons with disabilities of the same community resources that are used by and available to other citizens", and
(ii) participation by persons with disabilities in the same community activities in which nonhandicapped citizens participate, together with regular contact with nonhandicapped citizens," and
"(B) the residence by persons with disabilities in homes or in home-like settings which are in proximity to community resources, together with regular contact with nonhandicapped citizens in their communities."

There are four components of total integration:

1) Physical integration. The individual is placed in a building where "regular" activities go on (e.g., school, classroom, community center bowling alley, group home). Effectiveness is measured by amount of time the individual is physically present (e.g., 60 percent of the school day).

2) Social integration. The individual has opportunities to interact with able-bodied persons. Facilitated interactions occur in naturalistic settings (e.g., the playground, McDonalds, the classroom). Effectiveness is measured by the quantity and quality of interactions (e.g., amount of time interacting, speech acts, number of partners, attitudes of partners, etc.). The emotional components involved are very individualistic and hard to measure.

3) Academic or vocational integration. The individual participates in a structured learning or work environment with facilitation and support. Effectiveness is measured by how much and what is learned and accomplished.

4) Societal integration. The individual participates in community activities, i.e., leisure, vocational, living arrangement, public transportation, politics, etc. Effectiveness is measured against criteria, such as "how much like real life it is." (Blackstone and Montgomery, 1989)

As you begin to develop your assistive technology roadmap, ask these questions:

THE INTEGRATION IMPERATIVE

1) HAS YOUR STATE TASK FORCE OR COORDINATING COUNCIL ADOPTED INTEGRATION AS A CRITICAL OUTCOME MEASURE TO EVALUATE THE DELIVERY AND FUNDING OF TECHNOLOGY SERVICES?

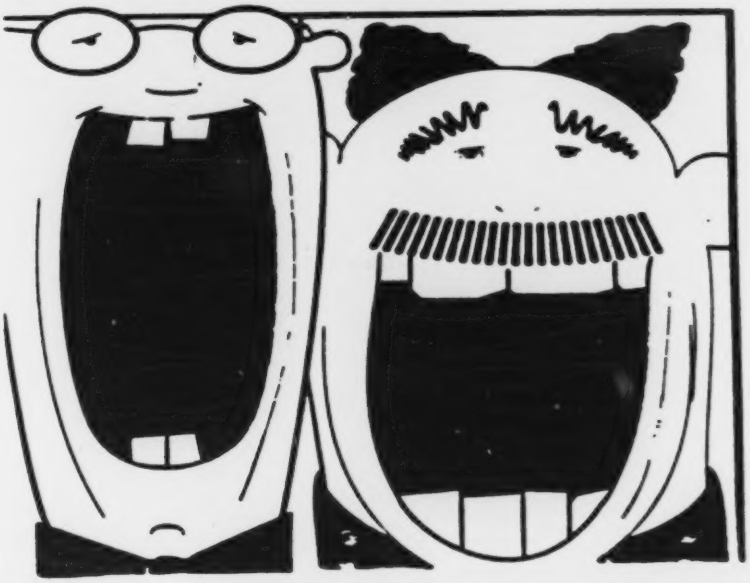
2) WILL TECHNOLOGY RESOURCES BE FOCUSED ON ELIMINATING BARRIERS TO INTEGRATION?

3) IDENTIFY BARRIERS AND POTENTIAL STRATEGIES TO ACHIEVE AN INTEGRATION OUTCOME OBJECTIVE AS A CRITICAL FACTOR TO DECIDE WHETHER OR NOT ASSISTIVE TECHNOLOGY SERVICES WILL BE PROVIDED. ASSIGN RESPONSIBILITIES. ESTABLISH TIMELINES.

PART IV

PROBLEM SOLVING

CHALLENGES



This section of the workbook outlines fourteen problem-solving challenges that should expand understanding of what is possible with public and private funding streams. They are challenges that will work most effectively as a group activity for parents, consumers, professionals, and administrators.

CHALLENGE NUMBER ONE

The Most Common Excuses

For Not Funding Assistive Technology

1) The law says we can't help you.

2) We would like to provide you funding, but we have limited resources.

3) We are payer of last resort, so come back to us after you have exhausted all other resources.

4) We don't agree these needs could be met by assistive technology.

5) What you want costs too much! We have limits on what we can spend on a single client.

6) You are not eligible for services from this agency.

7) Although this kind of device would be optimum for your needs, we are not required to provide that level of service.

8) Talk to your insurance company. That is who should assist you!

9) We can put you on a waiting list.

10) Our professional experts don't agree with your assessment of needs.

Action To Be Taken

1) For each excuse, list three effective responses.

2) For each excuse, assume a child of school age with a disability is seeking the support of assistive technology. List an effective response for each excuse.

3) For each excuse, assume an adult with a disability is seeking assistive technology support. List an effective response for each excuse.

CHALLENGE NUMBER TWO

The Funding Universe

Knowledge is power. It is important that we learn about all possible funding streams.

A. Please list all possible federal and state programs that could help fund assistive technology services and devices for young children, children of school age, adults, and individuals who are elderly.

CHALLENGE NUMBER TWO (continued)

Programs	State and Federal Funding Options
I. CHILDREN LESS THAN THREE YEARS OLD	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Programs	State and Federal Funding Options

II. CHILDREN OF PUBLIC SCHOOL AGE (3-21)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Programs	State and Federal Funding Options
III. ADULTS	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Programs State and Federal Funding Options

IV.) INDIVIDUALS WHO ARE ELDERLY

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

CHALLENGE NUMBER THREE

Definitions

Assistive technology is an intimidating term not well understood by parents, professionals, and persons with disabilities. Increasing basic understanding of a common definition of assistive technology will be a first step in building a statewide policy of enhanced funding options. P.L. 100-407, the Technology-Related Assistance Act includes a broad definition of assistive technology services and devices.

Action To Be Taken

1) Work cooperatively with individual potential funding sources to explore the parameters of their working definitions for assistive technology services and devices.

Funding Stream	Definitions	Key Phrases or Terminology	What Is Not Likely to be Included
A)			

Funding Stream	Definitions	Key Phrases or Terminology	What is not Likely to be Included
B)			
C).			

Funding Stream	Definitions	Key Phrases or Terminology	What is not Likely to be Included
D)			
E)			

2) Compare the definitions with those in the Tech Act on the following page and begin to explore the possibilities of an expanded definition.

TECHNOLOGY RELATED ASSISTANCE FOR INDIVIDUALS WITH DISABILITIES ACT
(P.L. 100-407)

DEFINITION - ASSISTIVE TECHNOLOGY DEVICE

"Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities." (P.L. 100-407).

DEFINITION - ASSISTIVE TECHNOLOGY SERVICE

"Any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. Such term includes -

(A) the evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual's customary environment;

(B) purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;

(C) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing of assistive technology devices;

(D) coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(E) training or technical assistance for an individual with disabilities, or, where appropriate, the family of an individual with disabilities; and

(F) training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities." (P.L. 100-407).

CHALLENGE NUMBER FOUR

Reading A State Plan

1. From the appropriate state agency, secure a copy of the current state plan:

   a) Vocational Rehabilitation P.L. 99-506;
   b) Education of Handicapped Children - Special Education P.L. 94-142;
   c) Early Intervention P.L. 99-457;
   d) Medicaid or Medical Assistance
   e) Developmental Disabilities
   f) Maternal and Child Health
   g) Independent Living

2. With each state plan, identify answers to the following questions:

   a) who is the designated lead agency - name of director, address, phone number
   b) list who is eligible for services and any priorities for service eligibility
   c) describe factors to be considered in determining eligibility
   d) list the services to be provided
   e) identify any individual program plan requirements
   f) develop a chart that simply explains the process of appeal with timelines when a consumer or family does not agree and wants to challenge individual program plan decisions regarding:

      - denial of eligibility
      - disagreement with what services should be provided
      - scope of services
      - payment for services
      - location for services to be delivered

3. State plans can and often are documents with over a hundred pages. Don't be afraid to ask questions. Be persistent in your search for answers that you understand.

CHALLENGE NUMBER FIVE

The Current Map

1. Identify the state agency who administers the following federally funded programs:

	Federal Funds	State Agency
1.	Early Intervention	Name Key contact Address Phone number
2.	Special Education	Name Key contact Address Phone number
3.	Vocational Rehabilitation	Name Key contact Address Phone number
4.	Office for the Blind	Name Key contact Address Phone number
5.	Maternal and Child Health	Name Key contact Address Phone number

	Federal Funds	State Agency
6.	Developmental Disabilities	Name Key contact Address Phone number
7.	Medicaid	Name Key contact Address Phone number
8.	Independent Living	Name Key contact Address Phone number
9.	Aging	Name Key contact Address Phone number

2. Obtain a copy in writing of each agency's procedures for funding technology services and devices. Who is the administrator responsible for technology service and funding determinations?

	Federal Funds	State Agency
1.	Early Intervention	Name Key contact Address Phone number
2.	Special Education	Name Key contact Address Phone number
3.	Vocational Rehabilitation	Name Key contact Address Phone number
4.	Office for the Blind	Name Key contact Address Phone number
5.	Maternal and Child Health	Name Key contact Address Phone number

	Federal Funds	State Agency
6.	Developmental Disabilities	Name Key contact Address Phone number
7.	Medicaid	Name Key contact Address Phone number
8.	Independent Living	Name Key contact Address Phone number
9.	Aging	Name Key contact Address Phone number

3. Develop a current menu of technology services for each funding stream in your state:

Funding Stream	Funded Technology Services & Devices	Eligibility Factors	Limits cost, scope	Mandatory or discretionary	Payor of last resort	Appeal procedure
1. Special education						
2. Vocational rehabilitation						

Funding Stream	Funded Technology Services & Devices	Eligibility Factors	Limits cost, scope	Mandatory or discretionary	Payor of last resort	Appeal procedure
3.						
4.						

Funding Stream	Funded Technology Services & Devices	Eligibility Factors	Limits cost, scope	Mandatory or discretionary	Payor of last resort	Appeal procedure
5.						
6.						

Funding Stream	Funded Technology Services & Devices	Eligibility Factors	Limits cost, scope	Mandatory or discretionary	Payor of last resort	Appeal procedure
7.						
8.						

Funding Stream	Funded Technology Services & Devices	Eligibility Factors	Limits cost, scope	Mandatory or discretionary	Payor of last resort	Appeal procedure
9.						

CHALLENGE NUMBER SIX

Changing the Menu

Certain services must be provided according to the law established by Congress. If the state is to receive federal funds, the state plan submitted to the designated federal agency must provide assurances the mandated services will be provided to all eligible individuals. There are also services a state has the option to include based on a menu of services the federal law authorizes, but does not require. Expanding the menu is a policy decision that may result in expansion of technology services and funding.

The first step in developing an advocacy strategy to expand the service menu included in a state plan requires an understanding and knowledge of what is possible by studying the law and regulations.

Action To Be Taken

1) From a public library, the designated state agency, your state Developmental Disabilities Council, or your Congressman and Senators, secure a copy of current federal law and regulations, for the following programs:

- Early Intervention (P.L. 99-457) (Part H)
- Special Education (P.L. 94-142) (Part B)
- State Operated Programs (P.L. 89-313)
- Vocational Rehabilitation(P.L. 99-506) Title I & VII
- Maternal and Child Health (P.L. 74-271) Title V
- Medicaid (ICF/MR and EPSDT)

2) For each law and accompanying set of regulations identify the list of mandatory and optional services authorized by Congress.

Example:

Medicaid

Mandatory	Optional
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	clinic services physical therapy
Inpatient and Outpatient Hospital Services	occupational therapy assistive technology devices and services
Physician Services	speech therapy

3) With each funding stream, please compare the list of services identified earlier by review of the appropriate state plan with the optional list of services identified by review of the law and regulations.

Example:

Title VII of P.L. 99-506 Independent Living Services

State Plan	Options In Law
1. No discussion of technology services	1) prosthesis and other assistive devices
	2) home site modifications

4) In coordination with consumer and advocacy groups, develop an agenda for changing the service menu in each state plan. Utilize the mandates of the Tech Act (P.L. 100-407) to push for system change and new levels of interagency coordination to expand funding options for assistive technology. Who will take the lead? What will it take for a greater percentage of funding to be allocated to assistive technology service without new federal or state dollars?

CHALLENGE NUMBER SEVEN

Individual and Systems Change

There are four federal mandates that have as a critical ingredient of service provision the development and implementation of individual program plans.

The four mandates are:

Program	Plan
. Early Intervention	Individual Family Services Plan (IFSP)
. Special Education	Individual Education Plan (IEP)
. Vocational Rehabilitation	Individual Written Rehabilitation Plan (IWRP)
. Medicaid (ICF/MR)	Individual Habilitation Plan (IHP)

Thousands of children and adults with disabilities in each state are the focus for discussion of unmet needs as part of the development of one of these four plans on an annual basis.

Action To Be Taken

1) Review the development and implementation policy and practices for each of these four types of individual program plans: For each of the four plans:

a) Are technology needs routinely considered and documented? (communication, mobility, assisted learning, environmental control or modification)
b) If not, are these policies in writing that specifically prohibit consideration of such needs? (Secure a copy of such a policy document)
c) If the prohibition is not a policy but a common practice or custom, ask the lead agency official to describe the practice in writing for your records.
d) Is their a standard(s) to assess need for assistive technology devices or services?
e) Secure a copy of the standards in writing and learn whether it is a state policy or just a common practice

f) If the standard of need has been met, will the lead agency fund at no cost the recommended assistive technology services and devices?
g) Is the funding stream a payor only of last resort?
h) Are there limits placed on cost per individual or the scope of services to be provided?
i) Are the services time limited?
j) Do I have the right to refuse co-party payments by my insurance company? Under what conditions?
k) Am I entitled to an independent evaluation of need? Who bears the cost?
l) Can I appeal the decision concerning need, eligibility, service scope or duration?
m) What is the appeal process? Am I entitled to the disputed services pending appeal?

2) In each state, a systems advocacy agenda can be refined in response to the answers to the above questions regarding each of the four federal mandates. It is my professional opinion from analyzing each of the four federal laws and accompanying regulations that:

1) Consideration of assistive technology needs cannot be presumptively prohibited.
2) Needs must be identified on an individual basis with the involvement and participation of the individual with disabilities, family members, and a qualified multidisciplinary team of experts.
3) Although each of the four mandates have different standards of need, services and devices must be provided at no cost to the individual if the standard(s) are met.
4) Failure to implement such a policy statewide consistently would be in violation of the law and jeopardize continued federal funding.

3) The critical questions will focus on:
a) the standard to cross the need threshold; and
b) the competencies of the plan team to adequately assess technology need.

Both issues require the focus of effort from consumers, parents, and professionals.

SAMPLE ADVOCACY AGENDA

1. No IFSP will be completed until the following question is answered:

   "Have we addressed the technology needs of this young child?"

2. No IEP will be completed until the following question is answered:

   "Have we addressed the technology needs of this child?"

3. No IWRP will be completed until the following question is answered:

   "Have we addressed the technology needs of this individual with a disability?"

4. No IHP will be completed until the following question is answered:

   "Have we considered technology needs for this individual as part of the definition of "active treatment"?"

A FEDERAL PUBLIC POLICY AGENDA

1. Increased Funding for P.L. 100-407

2. Passage of Medicaid Reform with a phase-in of mandated assistive technology services

3. Full Implementation of the Rehabilitation Technology Amendments of P.L. 99-506

4. Enforcement of a child with a disability's right to a free appropriate public education including assistive technology devices and services

5. Coordination of Technology Discretionary Funding

    - NIDRR, OSEP, RSA
    - NASA
    - VETERANS ADMINISTRATION
    - OHDS

CHALLENGE NUMBER EIGHT

The Road Map

The road map approach is based on the following premises:

a) There are over twenty federal funding streams that could pay for assistive technology devices and services.
b) There are situations where more than one funding stream will reimburse for assistive technology needs for an infant, child, teenager, or adult with a disability.
c) There are gaps in the funding picture for individuals of a certain age, with different types of disability, certain types of technology services, and length of time support will be provided.

The most critical challenge facing the potential technology user is to be able to find their way and successfully secure assistive technology services and funding. Where do I start? How do I avoid long delays, detours, roadblocks?

Action To Be Taken

1) Identify three distinct cities or communities in your state that could be distinguished from each other in size, service options, economic conditions, etc.

2) The objective is to develop a consumer or potential technology user road map that clearly marks funding options and identifies roadblocks, bridges, and tunnels. For each of the three locations, draw a separate road map for: a child of preschool age; a child of school age; and an adult.

Example

Macon, Georgia

1) Identify points of contact for potential funding (name, address, phone numbers). For each potential funding source, identify (a) eligibility requirements and standard of need; (b) approach to assess eligibility and meeting the need standard.

2) Attempt to map the coordination between funding sources.

3) Identify barriers to timely delivery of assistive technology services and devices.

4) Is there a written policy regarding funding of assistive technology devices or services? If not, could the current procedures and practices be put in writing?

Map for a Child of School Age

EPSDT

SSI

Medicaid

Public School

MCH

Title I

Independent Living

DD

CHALLENGE NUMBER NINE

Interagency Coordination

1) Coordination between agencies may be improved by:

a) adopting a common definition of assistive technology devices and services.
b) adopting the use of a intake form with a standard format that operationalizes the definition.
c) agreeing to a multidisciplinary approach to assess and identify need.
d) agreeing to a common fee structure.
e) agreeing to use the same quality indicators and outcome measures.

Action To Be Taken

1) Identify a lead agency and specific individual to coordinate the development of the common definition and intake form. Secure the commitment and involvement of the major funding sources.

2) Identify a lead agency and specific individual to coordinate issues related to assessment. Secure the commitment and involvement of the major funding sources.

3) After completion and agreement to implement the results of the above two objectives, select a lead agency and specific individual to coordinate the development of a possible fee structure. Secure the commitment and involvement of the major funding sources.

4) Select a lead agency and specific individual to develop a set of quality indicators and performance measures. Secure the commitment and involvement of the major funding sources.

In all four work groups; it is critical that persons with disabilities and parents be involved in shaping the system response.

CHALLENGE NUMBER TEN

Who Has The Responsibility?

Who has the responsibility to assist persons with disabilities and their families obtain funding for assistive technology services and devices? We all do. We as a local nonprofit service agency, the vocational rehabilitation counselor, the local public school, state agencies, manufacturers and dealers, and independent living centers.

The SMART Exchange, a federally funded project of the National Institute on Disability and Rehabilitation Research (NIDRR) and United Cerebral Palsy Associations, developed a set of quality indicators to assist individuals and agencies plan, implement, and evaluate technology services. One of the major responsibilities identified for an agency who is delivering technology services must be a commitment to assist consumers in obtaining funding.

4.0 Procedures for Assisting Consumers in Obtaining Funding.

4.1 The organization demonstrates the knowledge of established funding options and has written guidelines for its use.

4.2 Specified staff have the responsibility to coordinate funding procedures and explore cooperative funding alternatives.

4.3 A commitment has been made to assist consumers, their families and/or their advocates through an appeal process which is germane to the available funding stream.

4.4 If third party payment is not available, the organization is committed to locating funds from additional sources.

4.5 Innovative options are used to expand availability of technology services and/or devices (i.e. through loan programs and/or equipment recycling, etc.).

4.6 The organization provides information and training to funding sources and elected officials regarding the benefits of assistive technology services and devices.

4.7 The organization has made a commitment to learning about new funding options and shares this knowledge with others.

Action To Be Taken

1) State agencies need to make a commitment to clearly define their reimbursement practices. Each agency should select an individual to be responsible for clarifying reimbursement policy concerning assistive technology and provide multiple approaches to insuring that agency staff at a local and regional level are knowledgeable and informed about the process.

2) Local nonprofit agencies should make a similar commitment by identifying a staff member to coordinate technology funding practices and explore cooperative funding options in the public and private sector.

CHALLENGE NUMBER ELEVEN

Private Insurance

Many individuals with disabilities have the potential of securing reimbursement for assistive technology services and devices through group health insurance coverage. In many situations, an individual with a disability is the beneficiary of coverage secured by their parents through insurance offered by their employer. A standard health insurance coverage plan sets out the parameters for payment decisions regarding specific types of health services. Most coverage includes a deductible amount of costs that must be paid by the individual and family before the insurer reimburses a percentage of remaining health care costs. A typical policy covers 80% of the costs of physician and ancillary services.

It is unlikely for the insurance benefits plan to specifically list such services as rehabilitation engineering, or assistive devices. However, you may find listed coverage of physical and occupational therapy and therapeutic aids or medical devices prescribed by a physician. There is, in most instances, a fair amount of discretion allowed the claims adjuster and supervisors to interpret the intent of the employer agreed to insurance contract and the scope of services covered.

The important issues to focus on include:

- the reliance on an individual for decision making
- the standards to be met to cross the threshold of need to be entitled to a benefit
- the value or cost-effectiveness of reimbursement for a particular type of device or service.

Action To Be Taken

1) Cultivate a relationship with the various payer representatives in your service area.

2) Review carefully your benefits package described in your group health insurance package. Try to identify options that are broadly defined and could include assistive technology coverage.

3) Try by phone or better yet in person to meet with a claims supervisor to discuss possible coverage of specific types of assistive devices and services. Learn the steps in the approval process and most important of all the documentation needed to approve this type of claim. Additional coverage of assistive technology may be possible through liberal interpretation of the current insurance agreement.

4) As the parameters of current coverage are defined, you may want to meet with the appropriate individual at your place of employment (personnel office) to discuss possible expanded coverage. Expanded coverage need not necessarily greatly increase the cost to your employer.

There are many factors that are involved in determining the cost of a policy including number of individuals on the plan, type of benefit, extent of risk, and percentage of reimbursement. A coverage change may be of benefit to other employees and members of their family. You need not work on additional coverage alone.

5) Local service agencies and state agencies should also have a strong interest in clarifying the coverage of private insurance. Several major federal funding streams that flow to states and are available to provide assistance to individuals require co-payments. Many federal programs like Medicaid are payors of last resort. Only if all other funding options are exhausted including private insurance will Medicaid reimburse for a particular service.

State and local agencies working together could help educate payor representatives of private insurance companies about assistive technology services and devices. Working together, there could be developed common definitions, an acceptable process to assess need, and a clearer understanding of cost-effectiveness and other benefits.

CHALLENGE NUMBER TWELVE

Writing the Justification

Reimbursement for assistive technology from public funding sources and private insurers will most often succeed or fail depending upon the ability of the applicant to:

a) prove essential need according to the agency standard; and
b) write an acceptable justification.

Different funding streams have distinct orientations that will require wording the justification for the same device or service in different ways. For vocational rehabilitation funding, an individual with a disability must convince or justify to a rehabilitation counselor that acquisition of a particular assistive device will be a critical element in securing competitive employment. If the funding service is Medicaid, this device must respond to a medical problem and be prescribed by a physician. An augmentative communication device can be a prosthetic device to justify Medicaid funding. Terminology used in an application to a funder could spell the difference that results in success or failure in the authorization process.

Action To Be Taken

1) Set up meetings with:

   a) local special education director;
   b) local vocational rehabilitation office director; and
   c) your group health insurance claims supervisor
   d) other key potential funders
   (Meetings in person are better than by phone).

2) Obtain copies of the basic intake form and learn about the justification process for assistive technology. Give examples of devices and types of services.

3) Work together to develop an appropriate justification statement that includes:

   a) a description of the equipment in relationship to the potential user;
   b) the benefits of specific features of the device to the particular user;

c) detail the assessment process including the credentials of the assessment team, all devices considered, cost, and why the particular device was chosen; and
d) match the benefit from the device with a specific benefit covered by the funder.

Know and become an expert on the process. Many funding streams require application, and authorization before acquisition can be made. Other funding streams work on a reimbursement basis. Keep informed of changes in the process, the scope of coverage, and timelines. Always, be knowledgeable about an appeals process.

THE JUSTIFICATION

(Several examples)

Program	
1. Special Education	the child needs the services to benefit from special education
	any supplemental aid or service that would enable a child be placed in a regular education environment
	related services includes transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education
	case by case basis
2. Vocational Rehabilitation	rehabilitation technology services to render an individual with a disability employable
	telecommunications, sensory, and other technology devices
	case by case basis
3. Early Intervention	functional needs of child related to performance of self-help skills, adaptive behavior and play, and sensory, motor, and postural development
	adaptation of the environment selection, design and use of assistive devices to promote the acquisition of functional skills
	frequency, intensity, location, and method of delivery of services
	case by case basis

4. ICF/MR

5. EPSDT

CHALLENGE NUMBER THIRTEEN

Which Is Easier To Do?

This discussion would be appropriate for a meeting of your state Developmental Disabilities Council or a Coordinating Task Force set up to implement your state's response to the Technology-Related Assistance Act, P.L. 100-407. A representative of the following funding streams should be in attendance:

Vocational Rehabilitation
Medicaid
Special Education
Early Intervention
Maternal and Child Health
Independent Living

Action To Be Taken

1) The focus of discussion is which is easier to do:

   A) Create a new program

   B) Establish a new system

   C) Reallocate resources within an existing system

   D) Accept no responsibility at this time without new funding

   E) Draft interagency agreements detailing coordination of funding and process

   F) Implement interagency agreements

   G) Fund demonstration programs

   H) Include the private sector (insurance, nonprofits, dealers, manufacturers) as an integral part of the funding system

   I) Establish permanent systems change

2) After this discussion, draft a systems change agenda with the assignment of specific responsibilities and the establishment of timelines.

CHALLENGE NUMBER FOURTEEN

Federal Discretionary Grants

There are several federal agencies that each year will announce in the Federal Register availability of funding for training or demonstration programs specifically focused on assistive technology. Eligible nonprofits will usually have 30 to 60 days to respond to the request for grant proposals which are evaluated by independent review panels.

Although these grants are limited typically to three years and vary in funding levels from an average of $50,000 to $200,000 annually, they can influence significantly the continued evolution of technology-service delivery in your state and the level of understanding and knowledge of professionals, parents, and consumers. Grant funds can not be applied for by individuals or families. Eligible applicants are typically state agencies, nonprofit agencies, and universities. The time limited benefits may well result in system change with the involvement and interest of state agencies.

Action To Be Taken

1) You can contact the following federal agencies to be put on a mailing list for grant announcements:

1. Merle McPherson, Director
Division of Services for Children
with Special Health Care Needs
Office of Maternal and Child Health
Room 6-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2350

2. Jane DeWeerd, Handicap Specialist
Head Start
ACYF
330 C Street, SW, Room 2310-B
Washington, DC 20202
(202) 245-0562

3. Judith Schrag, Director
   Office of Special Education Programs
   330 C Street, SW
   Washington, DC 20202-2736
   (202) 732-1007

4. James Hamilton, Branch Chief
   Early Childhood Programs, DES
   Office of Special Education Programs
   330 C Street, SW
   Washington, DC 20202
   (202) 732-1084

5. William Graves, James Reswick, Carol Cohen
   National Institute on Disability and Rehabilitation Research
   330 C Street, SW
   Washington, DC 20202
   (202) 732-1134

6. Deborah McFadden, Commissioner
   Administration on Developmental Disabilities
   OHDS
   200 Independence Avenue, SW
   Room 356-D, HHH Building
   Washington, DC 20201
   (202) 245-2890

7. Nell Carney, Commissioner
   Rehabilitation Services Administration
   Department of Education
   330 C Street, SW, Room 3028
   Switzer Building
   Washington, DC 20202-2531
   (202) 732-1282

8. Marty Kaufman, Director
   Office of Special Education Programs
   Division of Innovation Development
   330 C Street, SW, Room 3529
   Washington, DC 20202-2341
   (202) 732-1064

9. Susan Parker
   Associate Commissioner for Disability Policy
   Office of Disability
   Social Security Administration
   Room 545 Altmeyer
   6401 Security Blvd.
   Baltimore, MD 21235
   (301) 965-0486

PART V

INFORMATION RESOURCES

A. Key Regulation Resources

1. Early Intervention Final Regulations Excerpts.
   P.L. 99-457
2. Education of Handicapped Children Act Final Regulations Excerpts
   P.L. 94-142.
3. Vocational Rehabilitation Final Regulations Excerpts
   P.L. 99-506.
4. Medicaid: ICF/MR Final Regulations Excerpts.
5. Early Periodic Screening Diagnosis and Treatment Statutory
   Language and Legislative History.

federal register

Thursday
June 22, 1989

Part III

Department of Education

34 CFR Part 303

Early Intervention Program for Infants and Toddlers With Handicaps; Final Regulations

suggestions for meeting specific legal requirements. Where a note sets forth a permissible course of action, a State may either rely upon the note or take any other course of action that meets the applicable requirements.

Executive Order 12606

Part H recognizes the unique and critical role that families play in the development of infants and toddlers who are eligible under this Part. It is clear, both from the statute and the legislative history of the Act, that the Congress intended for families to play an active, collaborative role in the planning and provision of early intervention services. Thus, these regulations, which are consistent with the requirements of Executive Order 12606—The Family—should have a positive impact on the family, because they strengthen the authority and encourage the increased participation of parents in meeting the early intervention needs of their children.

Executive Order 12612

These final regulations have been developed (1) to be responsive to the overarching request by hundreds of commenters that more guidance be provided in all major areas under this part, and (2) to be consistent with the principles of Executive Order 12612—Federalism. Every effort has been made to ensure that, to the extent possible, each State has the authority and flexibility to implement the provisions of this part in accordance with that State's own unique situation; and that decisions related to the planning, development, and implementation of the statewide system of early intervention services remain with the State.

Executive Order 12291

These regulations have been reviewed in accordance with Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulations established in the order.

Intergovernmental Review

This program is subject to the requirements of Executive Order 12372 and the regulations in 34 CFR part 79. The objective of the Executive Order is to foster intergovernmental partnership and a strengthened Federalism by relying on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

In accordance with the order, this document is intended to provide early notification of the Department's specific plans and actions for this program.

Assessment of Educational Impact

In the NPRM, the Secretary requested comments on whether the proposed regulations would require transmission of information that is being gathered by any other agency or authority of the United States.

Based on the response to the NPRM and on its own review, the Department has determined that the regulations in this document do not require transmission of information that is being gathered by or is available from any other agency or authority of the United States.

List of Subjects in 34 CFR Part 303

Education, Education of the handicapped, Grant program education, medical personnel, State educational agencies.

Dated: May 12, 1989.

(Catalogue of Federal Domestic Assistance Number 84.181: Early Intervention Programs for Infants and Toddlers with Handicaps)

Lauro F. Cavazos,

Secretary of Education.

The Secretary amends Title 34 of the Code of Federal Regulations by adding a new Part 303 to read as follows:

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Authority: 20 U.S.C. 1471-1485, unless otherwise noted.

Subpart A—General

Purpose, Eligibility, and Other General Provisions

§ 303.1 Purpose of the early intervention program for infants and toddlers with handicaps.

The purpose of this part is to provide financial assistance to States to—

(a) Develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with handicaps and their families;

(b) Facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage); and

(c) Enhance the States' capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with handicaps and their families.

(Authority: 20 U.S.C. 1471)

§ 303.2 Eligible applicants for an award.

Eligible applicants include the 50 States, Puerto Rico, the District of Columbia, the Secretary of the Interior, and the following jurisdictions: Guam, American Samoa, the Virgin Islands, the Republic of Palau, and the Commonwealth of the Northern Mariana Islands. The future eligibility of the Republic of Palau will be governed by the terms of the Compact of Free Association.

(Authority: 20 U.S.C. 1484)

§ 303.3 Activities that may be supported under this part.

Funds under this part may be used for the following activities:

(a) To plan, develop, and implement a statewide system of early intervention services for children eligible under this part and their families.

(b) For direct services for eligible children and their families that are not otherwise provided from other public or private sources.

(c) To expand and improve on services for eligible children and their families that are otherwise available, consistent with § 303.527.

(Authority: 20 U.S.C. 1472, 1479)

§ 303.4 Applicable regulations.

(a) The following regulations apply to this part:

(1) The Education Department General Administrative Regulations (EDGAR), including—

(i) Part 76 (State Administered Programs), except for § 76.103;

(ii) Part 77 (Definitions that Apply to Departmental Programs);

(iii) Part 79 (Intergovernmental Review of Department of Education Programs and Activities);

(iv) Part 80 (Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments);

of personnel listed in paragraph (e) of this section.

(iii) In conformity with an individualized family service plan; and

(iv) At no cost, unless, subject to § 303.520(b)(3), Federal or State law provides a system of payments by families, including a schedule of sliding fees; and

(4) Meet the standards of the State, including the requirements of this part.

(b) *Location of services.* To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps would participate.

(c) *General role of service providers.* To the extent appropriate, service providers in each area of early intervention services included in paragraph (d) of this section are responsible for—

(1) Consulting with parents, other service providers, and representatives of appropriate community agencies to ensure the effective provision of services in that area;

(2) Training parents and others regarding the provision of those services; and

(3) Participating in the multidisciplinary team's assessment of a child and child's family, and in the development of integrated goals and outcomes for the individualized family service plan.

(d) *Types of services; definitions.* Following are types of services included under "early intervention services," and, if appropriate, definitions of those services:

(1) "Audiology" includes—

(i) Identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques;

(ii) Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;

(iii) Referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;

(iv) Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;

(v) Provision of services for prevention of hearing loss; and

(vi) Determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

(2) "Case management services" means assistance and services provided by a case manager to a child eligible under this part and the child's family that are in addition to the functions and activities included under § 303.6.

(3) "Family training, counseling, and home visits" means services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of a child eligible under this part in understanding the special needs of the child and enhancing the child's development.

(4) "Health services" (See § 303.13).

(5) "Medical services only for diagnostic or evaluation purposes" means services provided by a licensed physician to determine a child's developmental status and need for early intervention services.

(6) "Nursing services" includes—

(i) The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;

(ii) Provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and

(iii) Administration of medications, treatments, and regimens prescribed by a licensed physician.

(7) "Nutrition services" includes—

(i) Conducting individual assessments in—

(A) Nutritional history and dietary intake;

(B) Anthropometric, biochemical, and clinical variables;

(C) Feeding skills and feeding problems; and

(D) Food habits and food preferences;

(ii) Developing and monitoring appropriate plans to address the nutritional needs of children eligible under this part, based on the findings in paragraph (b)(7)(i) of this section; and

(iii) Making referrals to appropriate community resources to carry out nutrition goals.

(8) "Occupational therapy" includes services to address the functional needs of a child related to the performance of self-help skills, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include—

(i) Identification, assessment, and intervention;

(ii) Adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and

(iii) Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

(9) "Physical therapy" includes—

(i) Screening of infants and toddlers to identify movement dysfunction;

(ii) Obtaining, interpreting, and integrating information appropriate to program planning, to prevent or alleviate movement dysfunction and related functional problems; and

(iii) Providing services to prevent or alleviate movement dysfunction and related functional problems.

(10) "Psychological services" includes—

(i) Administering psychological and developmental tests, and other assessment procedures;

(ii) Interpreting assessment results;

(iii) Obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and

(iv) Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

(11) "Social work services" includes—

(i) Making home visits to evaluate a child's living conditions and patterns of parent-child interaction;

(ii) Preparing a psychosocial developmental assessment of the child within the family context;

(iii) Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents;

(iv) Working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and

(v) Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

(12) "Special instruction" includes—

(i) The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;

(ii) Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan;

(iii) Providing families with information, skills, and support related to enhancing the skill development of the child; and

(iv) Working with the child to enhance the child's development.

(13) "Speech-language pathology" includes—

(i) Identification of children with communicative or oral pharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;

(ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oral pharyngeal disorders and delays in development of communication skills; and

(iii) Provision of services for the habilitation, rehabilitation, or prevention of communicative or oral pharyngeal disorders and delays in development of communication skills.

(14) "Transportation" (see § 303.23).

(e) *Qualified personnel.* Early intervention services must be provided by qualified personnel, including—

(1) Audiologists;

(2) Nurses;

(3) Nutritionists;

(4) Occupational therapists;

(5) Physical therapists;

(6) Physicians;

(7) Psychologists;

(8) Social workers;

(9) Special educators; and

(10) Speech and language pathologists.

(Authority: 20 U.S.C. 1472(2))

Note 1: With respect to the requirement in paragraph (b) of this section, the appropriate location of services for some infants and toddlers might be a hospital setting—during the period in which they require extensive medical intervention. However, for these and other eligible children, it is important that efforts be made to provide early intervention services in settings and facilities that do not remove the children from natural environments (e.g., the home, day care centers, or other community settings). Thus, it is recommended that services be community-based, and not isolate an eligible child or the child's family from settings or activities in which children without handicaps would participate.

Note 2: The list of services in paragraph (d) of this section is not exhaustive and may include other types of services, such as vision services, and the provision of respite and other family support services. There also are other types of personnel who may provide services under this part, including vision specialists, paraprofessionals, and parent-to-parent support personnel.

§ 303.13 Health services.

(a) As used in this part, "health services" means services necessary to enable a child to benefit from the other early intervention services under this part during the time that the child is receiving the other early intervention services.

(b) The term includes—

(1) Such services as clean intermittent catheterization, tracheotomy care, tube feeding, the changing of dressings or osteotomy collection bags, and other health services; and

(2) Consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other early intervention services.

(c) The term does not include the following:

(1) Services that are—

(i) Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); or

(ii) Purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose).

(2) Devices necessary to control or treat a medical condition.

(3) Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children.

(Authority: 20 U.S.C. 1472(2))

Note: The definition in this section distinguishes between the health services that are required under this part, and the medical-health services that are not required. The IFSP requirements in Subpart D provide that, to the extent appropriate, these other medical-health services are to be included in the IFSP, along with the funding sources to be used in paying for the services. Identifying these services in the IFSP does not impose an obligation to provide the services if they are otherwise not required to be provided under this part. (See § 303.344(e), and the note following that section.)

§ 303.14 IFSP.

As used in this part, "IFSP" means the individualized family service plan, as that term is defined in § 303.340(b).

(Authority: 20 U.S.C. 1477)

§ 303.15 Include; including.

As used in this part, "include" or "including" means that the items named are not all of the possible items that are covered whether like or unlike the ones named.

(Authority: 20 U.S.C. 1484)

§ 303.16 Infants and toddlers with handicaps.

(a) As used in this part, "infants and toddlers with handicaps" means individuals from birth through age two who need early intervention services because they—

(1) Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

(i) Cognitive development;

(ii) Physical development, including vision and hearing;

(iii) Language and speech development;

(iv) Psychosocial development; or

(v) Self-help skills; or

(2) Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

(b) The term may also include, at a State's discretion, children from birth through age two who are at risk of having substantial developmental delays if early intervention services are not provided.

(Authority: 20 U.S.C. 1472(1))

Note 1: As used in paragraph (a)(2) of this section, "high probability" is not intended to be viewed as a statistical term. Rather, the phrase "have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay" applies to conditions with known etiologies and developmental consequences. Examples of these conditions include Down Syndrome and other chromosomal abnormalities, sensory impairments, including vision and hearing, inborn errors of metabolism, microcephaly, severe attachment disorders, including failure to thrive, seizure disorders, and fetal alcohol syndrome.

Note 2: With respect to paragraph (b) of this section, children who are at risk may be eligible under this part if a State elects to extend services to that population, even though they have not been identified as handicapped.

Under this provision, States have the authority to define who would be "at risk of having substantial developmental delays if early intervention services are not provided." In defining the "at risk" population, States may include well-known biological and other factors that can be identified during the neonatal period, and that place infants "at risk" for developmental delay. Commonly cited factors relating to infants include low birth weight, respiratory distress as a newborn, lack of oxygen, brain hemorrhage, and infection. It should be noted that these factors do not predict the presence of a barrier to development, but they may indicate children who are at higher risk of developmental delay than children without these problems.

§ 303.17 Multidisciplinary.

As used in this part, "multidisciplinary" means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities in § 303.322, and development of the IFSP in § 303.342.

Lead agency responsibility. The lead agency shall ensure that an IFSP is developed and implemented for each eligible child, in accordance with the requirements of this part. If there is a dispute between agencies as to who has responsibility for developing or implementing an IFSP, the lead agency shall resolve the dispute, or assign responsibility.

(Authority: 20 U.S.C. 1477)

Note: In instances where an eligible child must have both an IFSP and an individualized service plan under another Federal program, it may be possible to develop a single consolidated document, provided that it (1) contains all of the required information in § 303.344, and (2) is developed in accordance with the requirements of this part.

§ 303.341 Meeting the IFSP requirements for years four and five.

(a) *Fourth year requirements.* No later than the beginning of the fourth year of a State's participation under this part, the State shall ensure that—

(1) Evaluations and assessments are conducted in accordance with § 303.322

(2) An IFSP is developed, in accordance with §§ 303.342(a) and 303.343 (a), for each child determined to be eligible under this part and the child's family; and

(3) Case management services are available to each eligible child and the child's family.

(b) *Requirements for the fifth year.* No later than the beginning of the fifth year of a State's participation under this part, a current IFSP must be in effect and implemented for each eligible child and the child's family.

(Authority: 20 U.S.C. 1476 (b)(2), (b)(4), 1477 (a)(2), (c))

§ 303.342 Procedures for IFSP development, review, and evaluation.

(a) *Meeting to develop initial IFSP; timelines.* For a child who has been evaluated for the first time and determined to be eligible, a meeting to develop the initial IFSP must be conducted within the 45 day time period in § 303.321(e).

(b) *Periodic review.* (1) A review of the IFSP for a child and the child's family must be conducted every six months, or more frequently if conditions warrant, or if the family requests such a review. The purpose of the periodic review is to determine—

(i) The degree to which progress toward achieving the outcomes is being made; and

(ii) Whether modification or revision of the outcomes or services is necessary.

(2) The review may be carried out by a meeting or by another means that is acceptable to the parents and other participants.

(c) *Annual meeting to evaluate the IFSP.* A meeting must be conducted on at least an annual basis to evaluate the IFSP for a child and the child's family, and, as appropriate, to revise its provisions. The results of any current evaluations conducted under § 303.322(c), and other information available from the ongoing assessment of the child and family, must be used in determining what services are needed and will be provided.

(d) *Accessibility and convenience of meetings.* (1) IFSP meetings must be conducted—

(i) In settings and at times that are convenient to families; and

(ii) In the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.

(2) Meeting arrangements must be made with, and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend.

(Authority: 20 U.S.C. 1477)

Note: The requirement for the annual evaluation incorporates the periodic review process. Therefore, it is necessary to have only one separate periodic review each year (i.e., six months after the initial and subsequent annual IFSP meetings), unless conditions warrant otherwise.

Because the needs of infants and toddlers change so rapidly during the course of a year, certain evaluation procedures may need to be repeated before conducting the periodic reviews and annual evaluation meetings in paragraphs (b) and (c) of this section.

§ 303.343 Participants in IFSP meetings and periodic reviews.

(a) *Initial and annual IFSP meetings.* (1) Each initial meeting and each annual meeting to evaluate the IFSP must include the following participants:

(i) The parent or parents of the child.

(ii) Other family members, as requested by the parent, if feasible to do so;

(iii) An advocate or person outside of the family, if the parent requests that the person participate.

(iv) The case manager that has been working with the family since the initial referral of the child for evaluation, or that has been designated by the public agency to be responsible for implementation of the IFSP.

(v) A person or persons directly involved in conducting the evaluations and assessments in § 303.322.

(vi) As appropriate, persons who will be providing services to the child or family.

(2) If a person listed in paragraph (a)(1)(v) of this section is unable to attend a meeting, arrangements must be made for the person's involvement through other means, including—

(i) Participating in a telephone conference call;

(ii) Having a knowledgeable authorized representative attend the meeting; or

(iii) Making pertinent records available at the meeting.

(b) *Periodic review.* Each periodic review must provide for the participation of persons in paragraphs (a)(1)(i) through (a)(1)(iv) of this section. If conditions warrant, provisions must be made for the participation of other representatives identified in paragraph (a) of this section.

(Authority: 20 U.S.C. 1477(b))

§ 303.344 Content of IFSP.

(a) *Information about the child's status.* (1) The IFSP must include a statement of the child's present levels of physical development (including vision, hearing, and health status), cognitive development, language and speech development, psychosocial development, and self-help skills.

(2) The statement in paragraph (a)(1) of this section must be based on professionally acceptable objective criteria.

(b) *Family information.* With the concurrence of the family, the IFSP - include a statement of the family's strengths and needs related to enhancing the development of the child

(c) *Outcomes.* The IFSP must include a statement of the major outcomes expected to be achieved for the child and family, and the criteria, procedures, and timelines used to determine—

(1) The degree to which progress toward achieving the outcomes is being made; and

(2) Whether modifications or revisions of the outcomes or services are necessary.

(d) *Early intervention services.* (1) The IFSP must include a statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes identified in paragraph (c) of this section, including—

(i) The frequency, intensity, location, and method of delivering the services; and

(ii) The payment arrangements, if any.

(2) As used in paragraph (d)(1)(i) of this section—

(i) "Frequency" and "intensity" mean the number of days or sessions that a service will be provided, the length of time the service is provided during session, and whether the service is provided on an individual or group basis;

(ii) "Location" means, subject to § 303.12(b), where a service is provided (e.g., in the child's home, early intervention centers, hospitals and clinics, or other settings, as appropriate to the age and needs of the individual child); and

(iii) "Method" means how a service is provided.

(e) *Other services.* (1) To the extent appropriate, the IFSP must include—

(i) Medical and other services that the child needs, but that are not required under this part; and

(ii) If necessary, the steps that will be undertaken to secure those services through public or private resources.

(2) The requirement in paragraph (e)(1) of this section does not apply to routine medical services (e.g., immunizations and "well-baby" care), unless a child needs those services and the services are not otherwise available or being provided.

(f) *Dates; duration of services.* The IFSP must include the projected dates for initiation of the services in paragraph (d)(1) of this section, and the anticipated duration of those services.

(g) *Case manager.* (1) The IFSP must include the name of the case manager from the profession most immediately relevant to the child's or family's needs, who will be responsible for the implementation of the IFSP and coordination with other agencies and persons.

(2) In meeting the requirements in paragraph (g)(1) of this section, the public agency may—

(i) Assign the same case manager to be responsible for implementing a child's and family's IFSP who was appointed at the time that the child was initially referred for evaluation; or

(ii) Appoint a new case manager.

(3) As used in paragraph (g)(1) of this section, the term "profession" includes "case management."

(h) *Transition at age three.* (1) The IFSP must include the steps to be taken to support the transition of the child, upon reaching age three, to—

(i) Preschool services under Part B of the Act, to the extent that those services are considered appropriate; or

(ii) Other services that may be available, if appropriate.

(2) The steps required in paragraph (h)(1) of this section include—

(i) Discussions with, and training of, parents regarding future placements and other matters related to the child's transition;

(ii) Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting; and

(iii) With parental consent, the transmission of information about the child to the local educational agency, to ensure continuity of services, including evaluation and assessment information required in § 303.322, and copies of IFSPs that have been developed and implemented in accordance with §§ 303.340 through 303.346.

(Authority: 20 U.S.C. 1477(d))

Note 1: Throughout the process of developing and implementing IFSPs for an eligible child and the child's family, it is important for agencies to recognize the variety of roles that family members play in enhancing the child's development. It also is important that the degree to which the needs of the family are addressed in the IFSP process are determined in a collaborative manner with the full agreement and participation of the parents of the child. Parents retain the ultimate decision in determining whether they, their child, or other family members will accept or decline services under this part.

Note 2: The early intervention services in paragraph (d) of this section are those services that a State is required to provide to a child in accordance with § 303.12.

The "other services in paragraph (e) of this section are services that a child or family needs, but that are neither required nor covered under this part. While listing the non-required services in the IFSP does not mean that those services must be provided, their identification can be helpful to both the child's family and the case manager, for the following reasons: First, the IFSP would provide a comprehensive picture of the child's total service needs (including the need for medical and health services, as well as early intervention services). Second, it is appropriate for the case manager to assist the family in securing the non-required services (e.g., by (1) determining if there is a public agency that could provide financial assistance, if needed, (2) assisting in the preparation of eligibility claims or insurance claims, if needed, and (3) assisting the family in seeking out and arranging for the child to receive the needed medical-health services).

Thus, to the extent appropriate, it is important for a State's procedures under this part to provide for ensuring that other needs of the child, and of the family related to enhancing the development of the child, such as medical and health needs, are considered and addressed, including determining (1) who will provide each service, and when, where, and how it will be provided, and (2) how the service will be paid for (e.g., through private insurance, an existing Federal-State funding source, such as Medicaid or EPSDT, or some other funding arrangement).

Note 3: Although the IFSP must include information about each of the items in paragraphs (b) through (h) of this section, this does not mean that the IFSP must be a detailed, lengthy document. It might be a brief outline, with appropriate attachments that address each of the points in the paragraphs under this section. It is important for the IFSP itself to be clear about (a) what services are to be provided, (b) the actions that are to be taken by the case manager in initiating those services, and (c) what actions will be taken by the parents.

Note 4: It is important for the lead agency to take steps to ensure a smooth and effective transition of children eligible under this part to special education and related services under Part B of the Act. This is especially critical if the lead agency and the State educational agency (SEA) are not the same agency in a State. In this situation, agreement between the two agencies regarding the responsibilities of each agency during the transition period is very important. Agreements could be in the form of existing or new interagency agreements. Examples of important areas that might be addressed in such agreements include the following:

1. The assignment of financial and other responsibilities during transition, including the (a) performance of evaluations, (b) development of individualized education programs (IEPs) that meet the requirements in 34 CFR 300.340 through 300.349, if appropriate, and (c) provision of services on a continuous, uninterrupted basis.

2. Procedures to ensure a smooth transfer of responsibilities from local service providers to local educational agencies (LEAs), including any requirements for continued services under this part that are the responsibility of the LEAs.

3. Other provisions necessary to ensure effective transition of children under this part to preschool services under Part B of the Act. Agreements that are made between the two agencies need to be flexible enough to ensure that gaps in services will not occur.

§ 303.345 Provision of services before evaluation and assessment are completed.

Early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment in § 303.322, if the following conditions are met:

(a) Parental consent is obtained.

(b) An interim IFSP is developed that includes—

(1) The name of the case manager who will be responsible, consistent with § 303.344(g), for implementation of the interim IFSP and coordination with other agencies and persons; and

(2) The early intervention services that have been determined to be needed immediately by the child and the child's family.

(c) The evaluation and assessment are completed within the time period required in § 303.322(e).

(Authority: 20 U.S.C. 1477(c))

Note: This section is intended to accomplish two specific purposes: (1) To facilitate the provision of services in the event that a child has obvious immediate needs that are identified, even at the time of referral (e.g., a physician recommends that a child with cerebral palsy begin receiving physical therapy as soon as possible); and (2)

PART 300—ASSISTANCE TO STATES FOR EDUCATION OF HANDICAPPED CHILDREN

Subpart A—General

PURPOSE, APPLICABILITY, AND GENERAL PROVISIONS REGULATIONS

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AUTHORITY: 20 U.S.C. 1411-1420, unless otherwise noted.

(1) In all direct contact with a child (including evaluation of the child), communication would be in the language normally used by the child and not that of the parents, if there is a difference between the two.

(2) If a person is deaf or blind, or has no written language, the mode of communication would be that normally used by the person (such as sign language, braille, or oral communication).

§ 300.10 Parent.

As used in this part, the term "parent" means a parent, a guardian, a person acting as a parent of a child, or a surrogate parent who has been appointed in accordance with § 300.514. The term does not include the State if the child is a ward of the State.

(Authority: 20 U.S.C. 1415)

Comment. The term "parent" is defined to include persons acting in the place of a parent, such as a grandmother or stepparent with whom a child lives, as well as persons who are legally responsible for a child's welfare.

§ 300.11 Public agency.

As used in this part, the term "public agency" includes the State educational agency, local educational agencies, intermediate educational units, and any other political subdivision of the State which are responsible for providing education to handicapped children.

(Authority: 20 U.S.C. 1412(2)(B); 1412(6); 1413(a))

§ 300.12 Qualified.

As used in this part, the term "qualified" means that a person has met State educational agency approved or recognized certification, licensing, registration, or other comparable requirements which apply to the area in which he or she is providing special education or related services.

(Authority: 20 U.S.C. 1417(b))

§ 300.13 Related services.

(a) As used in this part, the term "related services" means transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

(b) The terms used in this definition are defined as follows:

(1) "Audiology" includes:

(i) Identification of children with hearing loss;

(ii) Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing;

(iii) Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation;

(iv) Creation and administration of programs for prevention of hearing loss;

(v) Counseling and guidance of pupils, parents, and teachers regarding hearing loss; and

(vi) Determination of the child's need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.

(2) "Counseling services" means services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.

(3) "Early identification" means the implementation of a formal plan for identifying a disability as early as possible in a child's life.

(4) "Medical services" means services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services.

(5) "Occupational therapy" includes:

(i) Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;

(ii) Improving ability to perform tasks for independent functioning when functions are impaired or lost; and

(iii) Preventing, through early intervention, initial or further impairment or loss of function.

(6) "Parent counseling and training" means assisting parents in understanding the special needs of their child and providing parents with information about child development.

(7) "Physical therapy" means services provided by a qualified physical therapist.

(8) "Psychological services" include:

(i) Administering psychological and educational tests, and other assessment procedures;

(ii) Interpreting assessment results;

(iii) Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning.

(iv) Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and

(v) Planning and managing a program of psychological services, including psychological counseling for children and parents.

(9) "Recreation" includes:

(i) Assessment of leisure function;

(ii) Therapeutic recreation services;

(iii) Recreation programs in schools and community agencies; and

(iv) Leisure education.

(10) "School health services" means services provided by a qualified school nurse or other qualified person.

(11) "Social work services in schools" include:

(i) Preparing a social or developmental history on a handicapped child;

(ii) Group and individual counseling with the child and family;

(iii) Working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school; and

(iv) Mobilizing school and community resources to enable the child to receive maximum benefit from his or her educational program.

(12) "Speech pathology" includes:

(i) Identification of children with speech or language disorders;

(ii) Diagnosis and appraisal of specific speech or languge disorders;

(iii) Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;

(iv) Provisions of speech and language services for the habilitation or prevention of communicative disorders; and

(v) Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

(13) "Transportation" includes:

(i) Travel to and from school and between schools,

(ii) Travel in and around school buildings, and

(iii) Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a handicapped child.

(Authority: 20 U.S.C. 1401 (17))

Comment. With respect to related services, the Senate Report states:

> The Committee bill provides a definition of "related services," making clear that all such related services may not be required for each individual child and that such term includes early identification and assessment of handicapping conditions and the provision of services to minimize the effects of such conditions.

(Senate Report No. 94-168, p. 12 (1975))

The list of related services is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, and art, music, and dance therapy), if they are required to assist a handicapped child to benefit from special education.

There are certain kinds of services which might be provided by persons from varying professional backgrounds and with a variety of operational titles, depending upon requirements in individual States. For example, counseling services might be provided by social workers, psychologists, or guidance counselors; and psychological testing might be done by qualified psychological examiners, psychometrists, or psychologists, depending upon State standards.

Each related service defined under this part may include appropriate administrative and supervisory activities that are necessary for program planning, management, and evaluation.

§ 300.14 Special education.

(a) (1) As used in this part, the term "special education" means specially designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

(2) The term includes speech pathology, or any other related service, if the service consists of specially designed instruction, at no cost to the parents, to meet the unique needs of a handicapped child, and is considered "special education" rather than a "related service" under State standards.

(3) The term also includes vocational education if it consists of specially designed instruction, at no cost to the parents, to meet the unique needs of a handicapped child.

(b) The terms in this definition are defined as follows:

(1) "At no cost" means that all specially designed instruction is provided without charge, but does not preclude incidental fees which are normally charged to non-handicapped students or their parents as a part of the regular education program.

(2) "Physical education" is defined as follows:

(i) The term means the development of:

(A) Physical and motor fitness;

(B) Fundamental motor skills and patterns; and

(C) Skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).

(ii) The term includes special physical education, adapted physical education, movement education, and motor development.

(Authority: 20 U.S.C. 1401 (16))

(3) "Vocational education" means organized educational programs which are directly related to the preparation of individuals for paid or unpaid employment, or for additional preparation for a career requiring other than a baccalaureate or advanced degree.

(Authority: 20 U.S.C. 1401 (16))

Comment. (1) The definition of "special education" is a particularly important one under these regulations, since a child is not handicapped unless he or she needs special education. (See the definition of "handicapped children" in § 300.5.) The definition of "related services" (§ 300.13) also depends on this definition, since a related service must be necessary for a child to benefit from special education. Therefore, if a child does not need special education, there can be no "related services," and the child (because not "handicapped") is not covered under the Act.

(2) The above definition of vocational education is taken from the Vocational Education Act of 1963, as amended by Pub. L. 94-482. Under that Act, "vocational education" includes industrial arts and consumer and homemaking education programs.

Subpart B—State Annual Program Plans and Local Applications

ANNUAL PROGRAM PLANS—GENERAL

§ 300.110 Condition of assistance.

In order to receive funds under Part B of the Act for any fiscal year, a State must submit an annual program plan to the Secretary through its State educational agency.

(Authority: 20 U.S.C. 1232c(b), 1412, 1413)

§ 300.111 Contents of plan.

Each annual program plan must contain the provisions required in this subpart.

(Authority: 20 U.S.C. 1412, 1413, 1232c(b))

ANNUAL PROGRAM PLANS—CONTENTS

§ 300.121 Right to a free appropriate public education.

(a) Each annual program plan must include information which shows that the State has in effect a policy which insures that all handicapped children have the right to a free appropriate public education within the age ranges and timelines under § 300.122.

(b) The information must include a copy of each State statute, court order, State Attorney General opinion, and other State document that shows the source of the policy.

(c) The information must show that the policy:

(1) Applies to all public agencies in the State;

(2) Applies to all handicapped children;

(Authority: 20 U.S.C. 1401(19); 1412 (2)(B), (4), (6); 1414(a)(5))

Comment. The notice in paragraph (a) could also inform parents that they may bring other people to the meeting. As indicated in paragraph (c), the procedure used to notify parents (whether oral or written or both) is left to the discretion of the agency, but the agency must keep a record of its efforts to contact parents.

§ 300.346 Content of individualized education program.

The individualized education program for each child must include:

(a) A statement of the child's present levels of educational performance;

(b) A statement of annual goals, including short term instructional objectives;

(c) A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular educational programs;

(d) The projected dates for initiation of services and the anticipated duration of the services; and

(e) Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short term instructional objectives are being achieved.

(Authority: 20 U.S.C. 1401(19); 1412 (2)(B), (4), (6); 1414(a)(5); Senate Report No. 94-168, p. 11 (1975))

§ 300.347 Private school placements.

(a) *Developing individualized education programs.* (1) Before a public agency places a handicapped child in, or refers a child to, a private school or facility, the agency shall initiate and conduct a meeting to develop an individualized education program for the child in accordance with § 300.343.

(2) The agency shall insure that a representative of the private school facility attends the meeting. If the representative cannot attend, the agency shall use other methods to insure participation by the private school or facility, including individual or conference telephone calls.

(3) The public agency shall also develop an individualized educational program for each handicapped child who was placed in a private school or facility by the agency before the effective date of these regulations.

(b) *Reviewing and revising individualized education programs.* (1) After a handicapped child enters a private school or facility, any meetings to review and revise the child's individualized education program may be initiated and conducted by the private school or facility at the discretion of the public agency.

(2) If the private school or facility initiates and conducts these meetings, the public agency shall insure that the parents and an agency representative:

(i) Are involved in any decision about the child's individualized education program; and

(ii) Agree to any proposed changes in the program before those changes are implemented.

(c) *Responsibility.* Even if a private school or facility implements a child's individualized education program, responsibility for compliance with this part remains with the public agency and the State educational agency.

(Authority: 20 U.S.C. 1413(a)(4)(B))

§ 300.348 Handicapped children in parochial or other private schools.

If a handicapped child is enrolled in a parochial or other private school and receives special education or related services from a public agency, the public agency shall:

(a) Initiate and conduct meetings to develop, review, and revise an individualized education program for the child, in accordance with § 300.343; and

(b) Insure that a representative of the parochial or other private school attends each meeting. If the representative cannot attend, the agency shall use other methods to insure participation by the private school, including individual or conference telephone calls.

(Authority: 20 U.S.C. 1413(a)(4)(A))

§ 300.349 Individualized education program—accountability.

Each public agency must provide special education and related services to a handicapped child in accordance national origin, gender, age, or handicapping condition;

(4) The applicant has provided an adequate plan for the use of facilities, resources, supplies, and equipment;

(5) The budget for the project is reasonable and adequate to support the proposed activities; and

(6) The applicant provides an appropriate plan for the evaluation of all phases of the project.

(Approved by the Office of Management and Budget under Control Number 1820-0037)

(Authority: 29 U.S.C. 761a(e) and 76(a)(k))

§ 360.32 What are the priorities for funding under this program?

(a) Each year, the Secretary may establish priorities to support research training in one or more of the following areas of study:

(1) Medicine or medical specialties, such as physical medicine and rehabilitation; neurology; orthopedics; otolaryngology; rheumatology; psychiatry; family medicine; endocrinology; pediatrics; podiatry; dentistry; urology; plastic and reconstructive surgery; or maxillofacial prosthodontics.

(2) Allied health professions, such as physical therapy; occupational therapy; nursing; audiology; speech pathology; psychology; or recreational therapy.

(3) Engineering and rehabilitation technology fields, such as prosthetics and orthotics; engineering; design; architecture; computer applications; or biomechanics.

(4) Miscellaneous clinical or technical fields, such as rehabilitation counseling; social work; law; social and behavioral sciences; gerontology; or demographics.

(b) The Secretary establishes any priorities under this section through a notice in the FEDERAL REGISTER.

(Authority: 29 U.S.C. 760-762)

Subpart E—What Conditions Must Be Met After an Award?

§ 360.40 What is the required duration of the training?

A grantee shall provide training to individuals that is not less than one academic year in duration, unless a longer training period is required to ensure that each trainee is qualified to conduct independent research upon completion of the course of training. (Note: For fiscal year 1988 only, the minimum required training period is two academic years.)

(Authority: 29 U.S.C. 760-762)

§ 360.41 What level of participation is required of trainees?

Individuals who are receiving training under this program shall devote a minimum of eighty percent of their time to the activities of the training program during the training period.

(Authority: 29 U.S.C. 760-762)

PART 361—THE STATE VOCATIONAL REHABILITATION SERVICES PROGRAM

Subpart A—General

Sec.
361.1 The State vocational rehabilitation services program.

Subpart B—State Plans for Vocational Rehabilitation Services

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(1) A part providing detailed commitments specified by the Secretary that must be amended or reaffirmed every three years, including—

(i) A description of how rehabilitation engineering services will be provided to assist an increasing number of individuals with handicaps;

(ii) A summary of the results of a comprehensive, Statewide assessment of the rehabilitation needs of individuals with severe handicaps residing within the State and the State's response to the assessment; and

(iii) An acceptable plan under 34 CFR Part 363.

(2) A part containing a fiscal year programmming description, based on the findings of the continuing Statewide studies (§ 361.17), the annual evaluation of the effectiveness of the State's program (§ 361.17) and other pertinent reviews and studies. This annual programming description must include:

(i) Changes in policy resulting from the continuing Statewide studies and the annual evaluation of the effectiveness of the program;

(ii) Estimates of the number of individuals with handicaps who will be served with funds provided under the Act;

(iii) A description of the methods used to expand and improve services to those individuals who have the most severe handicaps, including individuals served under 34 CFR Part 363;

(iv) A justification for and description of the order of selection (§ 361.36) of individuals with handicaps to whom vocational rehabilitation services will be provided (unless the designated State unit assures that it is serving all eligible individuals with handicaps who apply);

(v) A description of the outcome and service goals to be achieved for individuals with handicaps in each priority category within the order of selection in effect in the State and the time within which these goals may be achieved. These goals must include those objectives, established by the State unit and consistent with those set by the Secretary in instructions concerning the State plan, that are measurable in terms of service expansion or program improvement in specified program areas, and that the State unit plans to achieve during a specified period of time; and

(vi) A description of the plans, policies, and methods to be followed to assist in the transition from education to employment-related activities, including a summary of the previous year's activities and accomplishments.

(c) *Separate part relating to rehabilitation of the blind.* If a separate State agency for the blind administers or supervises the administration of that part of the State plan relating to the rehabilitation of blind individuals, that part of the State plan must meet all requirements applicable to a separate State plan.

(d) *Consolidated rehabilitation plan.* The State may choose to submit a consolidated rehabilitation plan which includes the State plan for vocational rehabilitation services and either the State plan for independent living rehabilitation services or the State's plan for its program for persons with developmental disabilities, or both. If the State's plan for persons with developmental disabilities is included, the State planning and advisory council for developmental disbilities and the agency or agencies administering the State's program for persons with developmental disabilities must have concurred in the submission of the consolidated rehabilitation plan. A consolidated rehabilitation plan must comply, and be administered in accordance with this Act and the Developmental Disabilities Assistance and Bill of Rights Act, as amended. The Secretary may approve the consolidated rehabilitation plan to serve as the substitute for the separate plans which would otherwise be required.

(e) *Designation of a new State agency or a new State unit.* Before designating a new State agency or a new State unit, the chief administrative officer of the State agency must assure the Secretary in writing that the vocational rehabilitation program will continue to operate in conformity with the most recent approved State plan, until a new State plan is submitted. The State agency must submit a new State plan within 90 days following the designation of a new State agency or a new State unit.

(Authority: Secs. 101(a)(6) of the Act; 29 U.S.C. 721(a)(6))

[46 FR 5526, Jan. 19, 1981, as amended at 53 FR 16985, May 12, 1988]

§ 361.31 Eligibility for vocational rehabilitation services.

(a) *General provisions.* (1) The State plan must assure that eligibility requirements are applied by the designated State unit without regard to sex, race, age, creed, color, or national origin of the individual applying for service. The State plan must also assure that no group of individuals is excluded or found ineligible solely on the basis of type of disability. With respect to age, the State plan must assure that no upper or lower age limit is established which will, in and of itself, result in a finding of ineligibility for any individual with handicaps who otherwise meets the basic eligibility requirements specified in paragraph (b) of this section.

(2) The State plan must assure that no residence requirement, durational or other, is imposed which excludes from services any individual who is present in the State.

(b) *Basic conditions.* The State plan must assure that eligibility is based only upon:

(1) The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment; and

(2) A reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

(c) *Interim determination of eligibility.* The State plan may provide for vocational rehabilitation services to be initiated for an individual on the basis of an interim determination of eligibility. If the State chooses this approach, it must identify the criteria established for making an interim determination of eligibility, the procedures to be followed, the services which may be provided, and the period, not to exceed 90 days, during which services may be provided until a final determination of eligibility is made.

(Authority: Secs. 7(7)(A), 12(c), 101(a)(6) and 101(a)(14) of the Act; 29 U.S.C. 706(7)(A), 711(c), 721(a)(6), and 721(a)(14))

[46 FR 5526, Jan. 19, 1981, as amended at 53 FR 16982, May 12, 1988]

§ 361.32 Evaluation of vocational rehabilitation potential: Preliminary diagnostic study.

(a) *Basic conditions.* The State plan must assure that, in order to determine whether any individual is eligible for vocational rehabilitation services, there is a preliminary diagnostic study to determine:

(1) Whether the individual has a physical or mental disability which for that individual constitutes or results in a substantial handicap to employment; and

(2) Whether vocational rehabilitation services may reasonably be expected to benefit the individual in terms of employability, or whether an extended evaluation of vocational rehabilitation potential is necessary to make this determination.

(b) *Scope of diagnostic study.* The State plan must assure that the preliminary diagnostic study includes examinations and diagnostic studies to make the determinations specified in paragraph (a) of this section. In all cases, the evaluation places primary emphasis upon determining the individual's potential for achieving a vocational goal.

(c) *Specific evaluations.* The State plan must also assure that the preliminary diagnostic study includes an appraisal of the current general health status of the individual based, to the maximum extent possible, on available medical information, and, as appropriate, evaluations by qualified personnel of the potential to benefit from rehabilitation engineering services. The State plan must further assure that in all cases of mental or emotional disorder, an examination is provided by a physician skilled in the diagnosis and treatment of such disorders, or by a psychologist licensed or certified in accordance with State laws and regulations, in those States where laws and regulations pertaining to the practice of psychology have been established.

(Authority: Secs. 7(5) and 103(a)(1) of the Act; 29 U.S.C. 706(5) and 723(a)(1))

[46 FR 5526, Jan. 19, 1981, as amended at 53 FR 16985, May 12, 1988]

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ditions and procedures will be met or carried out.

(1) This decision is made only with the full participation of the individual, or, as appropriate, the individual's parent, guardian, or other representative, unless the individual has refused to participate, the individual is no longer present in the State or the individual's whereabouts are unknown, or the individual's medical condition is rapidly progressive or terminal. When the full participation of the individual or a representative of the individual has been secured in making the decision, the views of the individual are recorded in the individualized written rehabilitation program; S8010

(2) The rationale for the ineligibility decision is recorded as an amendment to the individualized written rehabilitation program certifying that the provision of vocational rehabilitation services has demonstrated that the individual is not capable of achieving a vocational goal, and a certification of ineligibility under § 361.35(c) is then executed; and

(3) There will be a periodic review, at least annually, of the ineligibility decision in which the individual is given opportunity for full consultation in the reconsideration of the decision, except in situations where a periodic review would be precluded because the individual has refused services or has refused a periodic review, the individual is no longer present in the State, the individual's whereabouts are unknown, or the individual's medical condition is rapidly progressive or terminal. The first review of the ineligibility decision is initiated by the State unit. Any subsequent reviews, however, are undertaken at the request of the individual.

(Authority: Secs. 101(a)(9) and 102 of the Act; 29 U.S.C. 721(a)(9) and 722)

[46 FR 5526, Jan. 19, 1981, as amended at 53 FR 16982, 16986, May 12, 1988]

§ 361.41 The individualized written rehabilitation program: Content.

(a) *Scope of content.* The State plan must assure that each individualized written rehabilitation program is based on a determination of employability designed to achieve the vocational objective of the individual and is developed through assessments of the individual's particular rehabilitation needs. Each individualized written rehabilitation program must, as appropriate, include but not be limited to, statements concerning—

(1) The basis on which a determination of eligibility has been made, or the basis on which a determination has been made that an extended evaluation of vocational rehabilitation potential is necessary to make a determination of eligibility;

(2) The long-range and intermediate rehabilitation objectives established for the individual based on an assessment determined through an evaluation of rehabilitation potential;

(3) The specific rehabilitation services to be provided to achieve the established rehabilitation objectives including, if appropriate, rehabilitation engineering services;

(4) An assessment of the expected need for post-employment services;

(5) The projected dates for the initiation of each vocational rehabilitation service, and the anticipated duration of each service;

(6) A procedure and schedule for periodic review and evaluation of progress toward achieving rehabilitation objectives based upon objective criteria, and a record of these reviews and evaluations;

(7) A reassessment, prior to case closure, of the need for post-employment services;

(8) The views of the individual with handicaps, or as appropriate, that individual and a parent, guardian, or other representative, including other suitable professional and informed advisors, concerning the individual's goals and objectives and the vocational rehabilitation services being provided;

(9) The terms and conditions for the provision of vocational rehabilitation services, including responsibilities of the individual with handicaps in implementing the individualized written rehabilitation program, the extent of client participation in the cost of services, if any, and the extent to which comparable services and benefits are available to the individual under any other program;

(10) An assurance that the individual with handicaps has been informed of that individual's rights and the means by which the individual may express and seek remedy for any dissatisfaction, including the opportunity for a review of rehabilitation counselor or coordinator determinations under § 361.48;

(11) An assurance that the individual with handicaps has been provided a description of the availability of a client assistance program established under section 112 of the Act;

(12) The basis on which the individual has been determined to be rehabilitated under § 361.43; and

(13) The plans for the provision of post-employment services after a suitable employment goal has been achieved and the basis on which those plans are developed; and, if appropriate for individuals with severe handicaps, a statement of how these services will be provided or arranged through cooperative agreements with other service providers.

(b) *Supported employment placements.* Each individualized written rehabilitation program must also contain, for individuals with severe handicaps for whom a vocational objective of supported employment has been determined to be appropriate—

(1) A description of the time-limited services, not to exceed 18 months in duration, to be provided by the State unit; and

(2) A description of the extended services needed, an identification of the State, Federal, or private programs that will provide the continuing support, and a description of the basis for determining that continuing support is available in accordance with 34 CFR 363.11(e)(2).

(c) *Coordination with education agencies.* When services are being provided to a handicapped individual who is also eligible for services under the Education for Handicapped Children Act, the individualized written rehabilitation program is prepared in coordination with the appropriate education agency and includes a summary of relevant elements of the individualized education program for that individual.

(Authority: Secs. 101 (a)(9), (a)(11), 102 and 634(a) of the Act; 29 U.S.C. 721 (a)(9), (a)(11), 722, and 795m)

[46 FR 5526, Jan. 19, 1981, as amended at 53 FR 16986, May 12, 1988]

§ 361.42 Scope of State-unit program: Vocational rehabilitation services for individuals.

(a) *Scope of services.* The State plan must assure that, as appropriate to the vocational rehabilitation needs of each individual, the following vocational rehabilitation services are available:

(1) Evaluation of vocational rehabilitation potential, including diagnostic and related services incidental to the determination of eligibility for, and the nature and scope of services to be provided;

(2) Counseling and guidance, including personal adjustment counseling, to maintain a counseling relationship throughout the program of services for an individual with handicaps, referral necessary to help individuals with handicaps secure needed services from other agencies, and advising clients and client applicants about client assistance programs under 34 CFR Part 370.

(3) Physical and mental restoration services, necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive;

(4) Vocational and other training services, including personal and vocational adjustment, books, tools, and other training materials except that no training or training services in institutions of higher education (universities, colleges, community/junior colleges, vocational schools, technical institutes, or hospital schools of nursing) may be paid for with funds under this part unless maximum efforts have been made by the State unit to secure grant assistance in whole or in part from other sources;

(5) Maintenance, including payments, not exceeding the estimated cost of subsistence and provided at any time after vocational rehabilitation services have begun through the time when postemployment services are being provided. Maintenance covers that individual's basic living ex-

penses, such as food, shelter, clothing, and other subsistence expenses which are necessary to support and derive the full benefit of the other vocational rehabilitation services being provided;

(6) Transportation, including necessary travel and related expenses including subsistence during travel (or per diem payments in lieu of subsistence) in connection with transporting individuals with handicaps and their attendants or escorts for the purpose of supporting and deriving the full benefit of the other vocational rehabilitation services being provided. Transportation may include relocation and moving expenses necessary for achieving a vocational rehabilitation objective;

(7) Services to members of an individual with handicaps's family when necessary to the vocational rehabilitation of the individual with handicaps;

(8) Interpreter services and note-taking services for the deaf, including tactile interpreting for deaf-blind individuals;

(9) Reader services, rehabilitation teaching services, note-taking services and orientation and mobility services for the blind;

(10) Telecommunications, sensory and other technological aids and devices;

(11) Recruitment and training services to provide new employment opportunities in the fields of rehabilitation, health, welfare, public safety, law enforcement and other appropriate public service employment;

(12) Placement in suitable employment;

(13) Post-employment services necessary to maintain or regain other suitable employment;

(14) Occupational licenses, including any license, permit or other written authority required by a State, city or other governmental unit to be obtained in order to enter an occupation or enter a small business, tools, equipment, initial stocks (including livestock) and supplies;

(15) Rehabilitation engineering services; and

(16) Other goods and services that can reasonably be expected to benefit an individual with handicaps in terms of employability.

(b) *Written policies.* The State plan must also assure that the State unit establishes and maintains written policies covering the scope and nature of each of the vocational rehabilitation services specified in paragraph (a) of this section, and the conditions, criteria, and procedures under which each service is provided.

(c) *Special requirements.* In the case of telecommunications, sensory, and other technological aids and devices, the written policies must ensure that individualized prescriptions and fittings are performed only by individuals licensed in accordance with State licensure laws, or by appropriate certified professionals. Any hearing aid recommended on the basis of an evaluation of the auditory system must be fitted in accordance with the specifications of the findings obtained under § 361.33. Newly developed aids and devices not requiring individualized fittings must meet any engineering and safety standards recognized by the Secretary.

(Authority: Secs. 101(a)(6) and 103(a) of the Act; 29 U.S.C. 721(a)(6) and 723(a))

[46 FR 5526, Jan. 19, 1981, as amended at 53 FR 16982, 16986, May 12, 1988]

§ 361.43 Individuals determined to be rehabilitated.

(a) *Minimum requirements.* The State plan must assure that an individual determined to be rehabilitated, must have been, as a minimum:

(1) Determined to be eligible under § 361.35(a);

(2) Provided an evaluation of vocational rehabilitation potential, and counseling and guidance as essential vocational rehabilitation services;

(3) Provided appropriate and substantial vocational rehabilitation services in accordance with the individualized written rehabilitation program developed under § 361.40 and § 361.41; and

(4) Determined to have achieved and maintained a suitable employment goal for at least 60 days.

(b) *Post-employment services.* The State plan must also assure that after an individual has been determined to be rehabilitated, the State unit will provide post-employment services if

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Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 431, 435, 440, 442, and 483

Medicaid Program; Conditions for Intermediate Care Facilities for the Mentally Retarded; Final Rule

483.440 Condition of participation:
Active treatment services.

(a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent

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implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) *Standard: Admissions, transfers, and discharge.* (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must—

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) *Standard: Individual program plan.* (1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must—

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

(iii) Identify the client's specific developmental and behavioral management needs;

(iv) Identify the client's need for services without regard to the actual availability of the services needed; and

(v) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives. These objectives must—

(i) Be stated separately, in terms of a single behavioral outcome;

(ii) Be assigned projected completion dates;

(iii) Be expressed in behavioral terms that provide measurable indices of performance;

(iv) Be organized to reflect a developmental progression appropriate to the individual; and

(v) Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan must specify:

(i) The methods to be used;

(ii) The schedule for use of the method;

(iii) The person responsible for the program;

(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

(v) The inappropriate client behavior(s), if applicable; and

(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan must also:

(i) Describe relevant interventions to support the individual toward independence.

(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

(iv) Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

(d) *Standard: Program implementation.* (1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility must develop an active treatment schedule that outlines the

Omnibus Budget Reconciliation Act Of 1989

Amendments to Early and Periodic Screening and Diagnostic

furnished in rural areas than those furnished in metropolitan statistical areas.".

(c) PAYMENT FOR CERTAIN SERVICES IN CERTAIN FEDERALLY-FUNDED HEALTH CENTERS.—

(1) COVERAGE.—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended by striking "and" before "(B)" and by inserting before the semicolon at the end the following: ", and (C) ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age".

(2) PAYMENT AMOUNTS.—Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting ", and for payment for services described in section 1905(a)(2)(C) under the plan," after "provided by a rural health clinic under the plan".

(d) EFFECTIVE DATE.—(1) The amendments made by subsections (a) and (b) (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act.

(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6403. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(r) The term 'early and periodic screening, diagnostic, and treatment services' means the following items and services:

"(1) Screening services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

"(B) which shall at a minimum include—

"(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

"(ii) a comprehensive unclothed physical exam,

"(iii) appropriate immunizations according to age and health history,

"(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

"(v) health education (including anticipatory guidance).

"(2) Vision services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

"(3) Dental services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

"(4) Hearing services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

→ *"(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.*

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is

(C) EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED

Present law

States are required to cover early and periodic screening, diagnostic, and treatment (EPSDT) services for most groups of Medicaid beneficiaries under age 21. Medicaid regulations provide the EPSDT screenings must include a health and developmental history, a comprehensive physical exam, vision and hearing testing, appropriate laboratory tests, and dental screening for children over 3 years old (or over 5 years old, with the Secretary's approval). The regulations require that States establish, in consultation with medical and dental organizations, a "periodicity schedule" for screenings, specifying services applicable at each stage of the beneficiary's life. States must also provide treatment for problems or conditions identified during screening. The regulations provide that, in addition to any treatment services normally covered under the State Medicaid plan, the State must provide dental care, appropriate immunizations, and vision and hearing treatment, including eyeglasses and hearing aids.

House bill (section 4213)

Codifies the current regulations on minimum components of EPSDT screening and treatment, with minor changes. Provides that screenings must include blood testing when appropriate, as well as health education. Eliminates the option of delaying dental screening to age 5. Requires distinct periodicity schedules for screening, vision, dental, and hearing services, and provides that services be furnished at intervals other than those specified in the periodicity schedule when medically necessary to identify and treat a suspected illness or condition. Provides that nothing in Medicaid law should be construed as limiting EPSDT providers to those that can furnish all the required EPSDT services or preventing providers qualified to furnish only a part of the EPSDT package from participating in the program. Requires States to report annually to the Secretary, by April 1 after the end of each fiscal year (beginning with FY 90), on the number of children receiving EPSDT screens, the number referred for follow-up treatment, and the number receiving dental services, by age and basis of Medicaid eligibility. Effective on enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with the following modifications: (1) States are required to provide any service that a State is allowed to cover with Federal matching funds under Medicaid that is required to treat a condition identified during a screen, whether or not the service is included in the State's Medicaid plan; (2) the Secretary is required to develop, by July 1, 1990, and every 12 months thereafter, EPSDT participation goals for each State, and States are required to include data on the extent to which they comply with these goals in their annual reports to the Secretary; and (3) the provision is effective April 1, 1990.

(D) EXTENSION OF PAYMENT PROVISIONS FOR MEDICALLY NECESSARY SERVICES TO CHILDREN IN DISPROPORTIONATE SHARE HOSPITALS

Present law

(1) States may establish reasonable durational limits on coverage of inpatient hospital services, but may not impose these limits on medically necessary services provided to children under 1 year old in hospitals serving a disproportionate number of low-income patients with special needs.

(2) If the State pays for inpatient services on a prospective basis (under which payment rates are established in advance and may not reflect the hospital's actual costs for covered services), the State must provide additional payment to disproportionate share hospitals for patients under 1 year old who are "outliers," that is, who incur exceptionally high costs or have long hospital stays.

House bill (section 4214)

(1) Requires States to waive durational limits for medically necessary inpatient services provided by disproportionate share hospitals to children under age 18. Applies to payments for calendar quarters beginning on or after July 1, 1990.

(2) Requires States with prospective payment systems to submit to the Secretary, by April 1, 1990, a State plan amendment providing for payment adjustments for services provided by disproportionate share hospitals after July 1, 1990, to children over age 1 but under age 18 who are outlier cases.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(E) REQUIRING "SECTION 209(B)" STATES TO PROVIDE MEDICAL ASSISTANCE TO DISABLED CHILDREN RECEIVING SSI BENEFITS

Present law

States are ordinarily required to provide Medicaid to any aged, blind, or disabled person receiving cash assistance under the Supplementary Security Income (SSI) program. However, section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603) provided that a State could use more restrictive eligiblity standards for Medicaid than those used for SSI if the State was using those standards for Medicaid on January 1, 1972.

House bill (section 4215)

Requires all States to provide Medicaid to persons under 18 who are receiving SSI benefits. Effective July 1, 1990.

Senate amendment

No provision.

cient time for a mother to make the transition from welfare to a job that offers health insurance coverage for her and her children.

To further encourage welfare families to work, the Committee bill would allow the States, at their option, to extend the current 12-month transitional coverage period for an additional 12 months (or 3, 6, or 9 months, as the State elects). Thus, a State could offer a working welfare family a total of 24 months of transitional Medicaid coverage (12 mandatory, 12 optional). Under the bill, the structure of the current mandatory benefit would remain unchanged. Thus, States could, at their option, impose the same income-related premium during this optional 12-month period that they are allowed to impose during the 2nd mandatory 6-month period. The Committee bill would also repeal the sunset.

The Committee bill would also make some technical corrections to current law. It clarifies that Medicaid transition coverage terminates at the close of the first month in which the family ceases to include a child, whether or not the child is a dependent child under part A of Title IV, or would be if needy. The Committee bill also clarifies that families who, prior to April 1, 1990, are receiving Medicaid extension coverage under the current law 9-month provision are entitled to continue receiving this extension coverage after that date until their 9-month coverage period expires.

Section 4213—Early and periodic screening, diagnostic, and treatment services

(a) In general.—Under current law, States are required to offer early and periodic screening, diagnostic, and treatment (EPSDT) services to children under age 21. States are required to inform all Medicaid-eligible children of the availability of EPSDT services, to provide (or arrange for the provision of) screening services in all cases when they are requested, and, to arrange for (directly or through referral to appropriate agencies or providers) corrective treatment for which the child health screening indicates a need.

The EPSDT benefit is, in effect, the nation's largest preventive health program for children. Each State must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by the screening. These services are available to children under EPSDT even if they are not available to other Medicaid beneficiaries under the State's plan.

The EPSDT benefit is not currently defined in statute. In the view of the Committee, as Medicaid coverage of poor children expands, both under current law and under the Committee bill, the EPSDT benefit will become even more important to the health status of children in this country. The Committee bill would therefore define the EPSDT benefit in statute to include four distinct elements: (1) screening services, (2) vision services, (3) dental services, and (4) hearing services. Each of these service elements would have its own periodicity schedule that meets reasonable practice standards. These items and services must be covered for children

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even if, under the State Medicaid plan, they are not offered to other groups of program beneficiaries.

Under the Committee bill, screening services must, at a minimum, include (1) a comprehensive health and developmental history (including assessment of both physical and mental health development), (2) a comprehensive unclothed physical exam, (3) appropriate immunizations according to age and health history, (4) laboratory tests (including blood lead level assessment appropriate for age and risk factors), and (5) health education (including anticipatory guidance). The Committee emphasizes that anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment. Anticipatory guidance includes health education and counselling to both parents and children.

Under the Committee bill, vision services must, at a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Dental services must, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. Hearing services must, at a minimum, include diagnosis and treatment for defects in hearing, including the provision of hearing aids. While States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit. For example, States may not limit dental care to emergency services only, *Mitchell* v. *Johnston*, 701 F. 2d 337 (5th Cir. 1983).

The Committee bill also clarifies the periodic nature of EPSDT services. With respect to screening services, the bill requires that they be provided at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations. The Committee intends that these health examinations be provided at intervals that are no greater than those described for well-child care in the "Guidelines for Health Supervision" (1981) of the American Academy of Pediatrics. The Committee is informed that some States use periodicity schedules for medical examinations to govern the frequency with which children may receive dental examinations. The Committee intends that, among older children, dental examinations occur with greater frequency than is the case with physical examinations.

The Committee bill also requires States to provide screening services at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary. The Committee emphasizes that the determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with a child outside of the health care system (e.g., State early intervention or special education programs, Head Start and day care programs, WIC and other nutritional assistance programs). As long as the child is referred to an EPSDT provider, the child would be entitled to an interperiodic health assessment (or dental, vision, or hearing assessment) or treatment services covered under the State plan.

These same considerations apply with respect to vision, dental, and hearing services, all of which must be provided when indicated as medically necessary to determine the existence of suspected illnesses or conditions. For example, assume that a child is screened at age 5 according to a State's periodicity schedule and is found to have no abnormalities. At age six, the child is referred to the school nurse by a teacher who suspects the child of having a vision problem. Under the Committee bill, the child can—and should—be referred at that point to a qualified provider of vision care for full diagnostic and treatment services, and the State must make payment for those services, even though the next regular vision exam under the State's periodicity schedule does not occur until age 7.

While States may, at their option, impose prior authorization requirements on treatment services, the Committee intends that, consistent with the preventive thrust of the EPSDT benefit, both the regular periodic screening services and the interperiodic screening services be provided without prior authorization.

The Committee notes that Medicaid-eligible children are entitled to EPSDT benefits even if they are enrolled in a health maintenance organization, prepaid health plan, or other managed care provider. The Committee expects that States will not contract with a managed care provider unless the provider demonstrates that it has the capacity (whether through its own employees or by contract) to deliver the full array of items and services contained in the EPSDT benefit. The Committee further expects that, in setting payment rates for managed care providers, the States will make available the resources necessary to conduct the required periodic and interperiodic screenings and to provide the required diagnostic and screening services.

The Committee bill clarifies that States are without authority to restrict the classes of qualified providers that may participate in the EPSDT program. Providers that meet the professional qualifications required under State law to provide an EPSDT screening, diagnostic, or treatment service must be permitted to participate in the program even if they deliver services in school settings, and even if they are qualified to deliver only one of the items or services in the EPSDT benefit.

(b) Report on the provision of EPSDT.—In order to assess the effectiveness of State EPSDT programs in reaching eligible children, the Committee bill would require the States to report annually to the Secretary, in a uniform form and manner established by the Secretary, the following information, broken down by age group and by basis of eligibility for Medicaid: (1) the number of children receiving child health screening services; (2) the number of children referred for corrective treatment (the need for which is disclosed by the screening); and (3) the number of children receiving dental services. These reports would be due April 1 of each year (beginning with April 1, 1991) and would apply to services provided

during the Federal fiscal year ending the previous September 30 (beginning with FY 1990).

Section 4214—Extension of payment provisions for medically necessary services in disproportionate share hospitals

(a) Coverage of medically necessary services for children.—Under current law, States may impose reasonable limits on the amount, duration, and scope of covered services. However, effective July 1, 1989, States are prohibited from imposing any fixed durational limit on Medicaid coverage of medically necessary inpatient hospital services provided to infants under age 1 by disproportionate share hospitals. As of January, 1989, according to the National Association of Childrens' Hospitals and Related Institutions, 12 States imposed durational limits on inpatient hospital services for children (Alabama, Alaska, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Missouri, Oregon, Tennessee, Texas, and West Virginia).

The purpose of the current law exception to fixed durational limits is to prohibit States from using arbitrary length of stay limitations (e.g., 20 days per year) to reduce payments for medically necessary services provided by hospitals, including many public and childrens' hospitals, that serve a disproportionate number of low-income patients. The Committee bill would extend this current law prohibition to any fixed durational limits on payment for inpatient services provided to children under age 18 by disproportionate share hospitals. The requirement is effective for inpatient hospital services furnished on or after July 1, 1990.

(b) Assuring adequate payment for inpatient hospital services for children in disproportionate share hospitals.—Under current law, States may reimburse hospitals for inpatient services on a prospective basis. If they choose to do so, States must, effective July 1, 1989, provide for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals involving exceptionally high costs or exceptionally long lengths of stay for infants under 1 year of age. According to the National Association of Children's Hospitals and Related Institutions, as of January, 1989, a total of 44 States pay for inpatient hospital services on a prospective basis; only 17 of these do not make outlier adjustments for high cost or long-stay cases (Alabama, Alaska, California, Colorado, Connecticut, D.C., Florida, Kentucky, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, Oklahoma, Tennessee, Texas, and Washington).

The Committee bill would extend this current law requirement to cases involving children from age 1 up to age 18. States that pay for inpatient hospital services on a prospective basis would be required to submit to the Secretary, no later than April 1, 1990, a State plan amendment that provides for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals after July 1, 1990, involving exceptionally high costs or exceptionally long lengths of stay for children age 1 up to age 18.

B. State Allotments and References

1. What Legislators Need to Know: Publication of National Conference of State Legislatures.
2. Federal Spending for MR/DD Services Chart of David Braddock, University of Illinois at Chicago.
3. List of Contacts by State of State Medicaid Directors Association.
4. State Allotments for P.L. 89-313, EHA, Preschool Grant Program and Part H Early Intervention.
5. Federal Special Education Contacts by State.
6. Survey of State MCH Program Activities.

WHAT LEGISLATORS NEED TO KNOW ABOUT MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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- *Early intervention services (ages zero through two years).* These services aim to help children with handicaps catch up to other children their age and diminish the need for specialized services later in life.

- *Preschool services (ages three through five).* Preschool instruction typically may cover motor development, communication, socialization, self-help, and cognitive development.

- *Special education services (school-aged children).* Tailored to the child's disability, these services focus on teaching age-appropriate skills. As the child grows older, instruction focuses increasingly on developing community life and vocational skills.

QUESTION FOUR: WHAT FEDERAL ASSISTANCE IS AVAILABLE?

Significant federal money is available to support persons with developmental disabilities. With careful planning, states can put together a system to make the most of federal support and stretch state dollars. The federal programs listed here are divided into categories of health care, home- and community-based services, housing, job training and placement, income support, and education.

Health Care

Medicaid. Medicaid is a federally matched, state-run medical assistance program for eligible low-income persons. The program often is referred to as Title XIX because of its authorizing legislation. The federal government establishes guidelines for the program and pays a portion of each state's medical assistance payments, ranging from a low of 50 percent to a high of 80 percent (see Table 1).

The federal government requires that certain groups be served under Medicaid, including recipients of Supplemental Security Income, subject to state restrictions, and Aid to Families with Dependent Children (AFDC). Some other categories of persons are eligible for Medicaid at the state's option.

For persons under 18 years of age with handicaps, parental income is counted as a resource available to the child. This situation creates severe hardship for many families who want to care for their children at home, but whose income makes them ineligible for Medicaid coverage. In fact, the policy actually encourages out-of-home placement.

States may elect to offer Medicaid services to children living at home without considering family income by modifying the state's Medicaid plan in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA) passed in 1982 (Section 134 of P.L. 97-35). The TEFRA coverage option has been elected by 19 states. Many of these states, however, apply it to a very narrow range of potential beneficiaries.[28]

Recent changes in Medicaid coverage that affect persons with disabilities include the following:[29]

- *COBRA-85*. The Consolidated Omnibus Budget Reconciliation Act of 1985 allows states to offer case management as an optional Medicaid-funded service.

- *OBRA-86*. The Omnibus Budget Reconciliation Act of 1986 authorizes state Medicaid coverage of at-home respiratory care services for ventilator-dependent individuals.

- *OBRA-87*. The Omnibus Budget Reconciliation Act of 1987 requires nursing homes that receive federal funds to place residents with disabilities who do not require 24-hour nursing in less restrictive settings. Question Seven addresses this issue.

- *Medicaid Technical Amendment of 1988 within P.L. 100-146*. States have the option to include special education-related services under P.L. 94-142 and early intervention and family support services under P.L. 99-457 in their state Medicaid plan in order to receive federal matching funds. These two federal laws are described in this question under "Education."

Table 1.

Federal Medicaid Matching Rate for Medical Assistance by State (FY 1990)

State	Rate	State	Rate
Alabama	73.21	Nebraska	61.12
Alaska	50.00	Nevada	50.00
Arizona	60.99	New Hampshire	50.00
Arkansas	74.58	New Jersey	50.00
California	50.00	New Mexico	72.25
Colorado	52.11	New York	50.00
Connecticut	50.00	North Carolina	67.46
Delaware	50.00	North Dakota	67.52
Florida	54.70	Ohio	59.57
Georgia	62.09	Oklahoma	68.29
Hawaii	54.50	Oregon	62.95
Idaho	73.32	Pennsylvania	56.86
Illinois	50.00	Rhode Island	55.15
Indiana	63.76	South Carolina	73.07
Iowa	62.52	South Dakota	70.90
Kansas	56.07	Tennessee	69.64
Kentucky	72.95	Texas	61.23
Louisiana	73.12	Utah	74.70
Maine	65.20	Vermont	62.77
Maryland	50.00	Virginia	50.00
Massachusetts	50.00	Washington	53.88
Michigan	54.54	West Virginia	76.61
Minnesota	52.74	Wisconsin	59.28
Missippippi	80.18	Wyoming	65.95
Missouri	59.18	District of Columbia	50.00
Montana	71.35	Puerto Rico	50.00

Source: U.S. Department of Health and Human Services, December 1989.

Medicare. Medicare is a federal health insurance program covering services to persons aged 65 and above, and to adults under age 65 and their offspring who have been receiving Social Security Disability Insurance benefits or Adult Disabled Child benefits for at least 24 months.

Maternal and Child Health block grant. This block grant enables states to develop or enhance systems to assure that children with special medical needs have access to primary health care services. States are given wide latitude over structure, target populations, and services. Every four federal dollars must be matched with three state dollars. Roughly 15 percent of the congressional appropriation for this block grant goes to fund discretionary grants referred to as Special Projects of Regional and National Significance (SPRANS).[30]

Technology Assistance Act (P.L. 100-407). This 1988 act is an effort by federal lawmakers to stimulate effective use of modern technology on behalf of all 43 million persons with disabling conditions, including the four million persons with developmental disabilities. States may apply to the secretary of the Department of Education for three-year grants of $50,000 per year to provide training and assistance and to establish model consumer-responsive service delivery systems to help individuals with disabilities use technology or devices.

Home- and Community-Based Services

Medicaid Home- and Community-Based Services Program (or the "2176 waiver"). Although originally intended to provide only medical services, Medicaid dollars may be used for a variety of nonmedical home- and community-based support services for recipients who otherwise would need more costly institutional care through the Home- and Community-Based Services Program. This program was authorized under Section 2176 of the Omnibus Budget Reconciliation Act of 1981. Federal support for 2176 waivers grew from $1.25 million in FY 1983 to $248 million in FY 1988.[31] As of 1988, 36 states offered services to 29,087 clients through this program.[32]

Medicaid's Model Waiver Option. Similar in purpose to that of the home- and community-based waivers, the model waiver allows Medicaid coverage of home care for individuals who otherwise would be served in an institutional setting at an equal or higher cost. Most participating states use the model waiver option to support home care for small numbers of targeted subpopulations, such as ventilator-dependent children living at home. These waivers sometimes are referred to as Model 50 waivers, Model 50/200 waivers, or Katie Beckett waivers. In many states, narrow eligibility criteria, complex application procedures, and poorly advertised availability prevent people from applying.[33]

Developmental Disabilities Act (P.L. 100-146). Reauthorized in 1987, this federal act aims to enable persons with developmental disabilities to achieve their maximum potential through three key concepts, which have become goals for many programs serving this population nationwide: independence, productivity, and integration into the community. The act provides grants for services such as case management, community living, and advocacy for persons with developmental disabilities. Most important, the act requires states to establish a Developmental Disabilities Council and to give the council planning authority to address the needs of persons with developmental disabilities. The act also requires each state to establish a protection and advocacy system funded by a separate line item to ensure legal rights for persons with developmental disabilities. States must devote 65 percent of the federal grant to federal priority areas, such as family support services, to strengthen the role of families as primary caregivers.

Crisis nurseries and respite care. An extension of the Temporary Child Care for Handicapped Children and Crisis Nursery Act of 1986 (P.L. 100-403), this program makes federal grants to states to fund agencies and organizations that provide respite care services for children with handicaps and nurseries for children in crisis because of abuse or neglect. Congress appropriated $5 million for this program in FY 1989. The program has the potential to become a more significant source of support for children with handicaps in the future.[34]

Other federal programs. Assistance for children with disabilities also may be provided from the Respite Care and Abandoned Infants Assistance Act and from Child Welfare Services.

Housing

Medicaid. The Social Security Amendments of 1971 authorized Medicaid to pay for 24-hour care provided by licensed intermediate care facilities for the mentally retarded. Reimbursements for ICF/MR services have become the largest federally financed program for persons with mental or physical handicaps. In FY 1988, $3.38 billion in federal matching funds was allocated to states for ICFs/MR. Of that amount, 84 percent went to large facilities of 16 or more people.[35]

Foster Care and Adoption Assistance (P.L. 96-272). Foster home placement is one residential option for children who have handicaps. Foster Care and Adoption Assistance (sometimes referred to as Title IV-E based on its authorizing legislation) is a 100 percent federally funded program that makes monthly payments to families who adopt or provide foster care for children with special needs. Each state receives an allotment based on the number of children receiving Aid to Families with Dependent Children. The children automatically are eligible for Medicaid after adoption, regardless of the adoptive family's eligibility for Medicaid.

Department of Housing and Urban Development (HUD) Section 8 rent subsidies. Persons who earn up to 80 percent of the median income in their area are eligible for Section 8 rent subsidies. Some states have used a percentage of their Section 8 allocations for persons with developmental disabilities.

Section 202/8 Direct Loan Program for Elderly or Handicapped. This HUD program provides 100 percent direct federal loans for constructing, renovating, or acquiring housing to serve persons who are elderly or handicapped.[36]

Job Training and Placement

The (Vocational) Rehabilitation Act of 1973 (P.L. 93-112). This act, amended in 1986 as P.L. 99-506, authorizes over one billion dollars in federal support for services to help persons with mental or physical handicaps find jobs. Services include evaluation of job potential, counseling, referral, vocational training, transportation, interpreter services for persons who are deaf, reader services, job placement, and postemployment services. Participating states are required to provide these services to individuals, emphasizing persons who are most severely disabled, on a case-by-case basis, as determined by an individualized, written rehabilitation plan. State programs must conform to federal law and regulations to be eligible for federal matching funds. The 1986 amendments created a new funding stream devoted solely to supported employment programs.

Job Training Partnership Act (P.L. 97-300). The Job Training Partnership Act (JTPA) provides 100 percent federally funded job training for persons who are economically disadvantaged. They receive classroom training in vocational skills and basic skills, as well as on-the-job training or other assistance to help find employment. Provisions for supportive services include child care and transportation. The Department of Labor allocates funds by formula to state governors, who allocate funds to local market areas. Each area must establish a Private Industry Council to make decisions at the local level. In 1987-88, 46,350 adults with handicaps and 47,740 youth with handicaps were served under the JTPA.[37]

Income Support

Supplemental Security Income. This 100 percent federally funded program provides income assistance to low-income elderly, blind, and disabled individuals. Eligibility is limited to persons with disabilities who are not capable of "substantial gainful employment." Persons with some income who do not qualify for the whole benefit may receive a partial SSI payment. No restrictions are placed on how this money may be spent. In 1988, federal SSI payments provided roughly one million persons with disabilities[38] with two billion dollars in benefits.[39]

As of January 1, 1990, the benefit award is $386 per month for single persons and $579 for couples. States may elect to supplement this payment and target specific needs of individuals with disabilities, such as home care services or board and care. SSI automatically entitles the recipient to Medicaid in all but 13 states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.[40] These states have additional requirements that SSI recipients must meet to be eligible for Medicaid.

Persons who live in institutions funded by Medicaid cannot receive the full SSI benefits. They can, however, qualify for a reduced benefit of $30 a month to cover personal needs.

Adult Disabled Child Benefits. Adults who were disabled in childhood are eligible for Adult Disabled Child benefits based on the earnings record of a deceased, disabled, or retired parent. This federal program is funded by Social Security payroll deductions. The child allotment is an additional 50 percent above the parent's primary insurance amount, up to a family maximum of $1,200 per month. Adult children of a deceased worker receive 75 percent of their parent's benefit. In 1988, Adult Disabled Child benefits amounted to $1.8 billion.[41]

Social Security Disability Insurance. SSDI provides monthly benefits to workers who have paid into the Social Security system but are unable to continue working because of a physical or mental impairment. Average monthly payments are $508 for an individual and $919 for an individual with a family. The program is totally funded by the federal government from payroll deductions. Recipients are eligible for Medicare benefits after two years.

Persons with developmental disabilities who benefit from SSDI include minor children with an eligible parent who receives an additional monthly allotment for the child, and individuals who are eligible by virtue of their employment history. Because persons with developmental disabilities experience their disability early in life, few accumulate the quarters of Social Security coverage necessary to qualify for SSDI. However, given the trend of more competitive and supported employment for persons with developmental disabilities, professionals expect a growing number to earn at levels to make them eligible for SSDI. In addition, workers in nonprofit organizations are covered under SSDI. Potentially, this means that persons working in sheltered workshops or supported employment and earning as little as $400 per quarter could qualify for disability insurance and be entitled to cash benefits, Medicare coverage, and retirement income.[42]

Food stamps and Aid to Families with Dependent Children. Food stamps and AFDC provide eligible persons who have mental and physical handicaps with resources needed to survive in the community. Food stamps are provided with federal funding to supplement consumer cash income. Residents in group living situations who receive SSI benefits now are eligible for food stamps. AFDC authorizes federal matching payments to states for providing aid and services to families with children who meet the state's eligibility criteria.

Education

The Education for All Handicapped Children Act of 1975 (P.L. 94-142). This seminal act is intended to guarantee all children between the ages of five and 21 with handicaps a free and appropriate public education, including needed support services in the least restrictive environment. These services may include transportation, speech pathology, audiology, psychological services, physical and occupational therapy, recreation, counseling, diagnosis and evaluation, and early identification and assessment.

Federal funds are provided to states on a matching basis, with 75 percent of monies designated to local education agencies for educational services and 25 percent provided to state education agencies. Although the law provides for federal assistance to meet up to 40 percent of the excess costs of special education, in reality, federal assistance is much less. In 1986, federal expenditures for special education were $1.16 billion--substantially less than the estimated 12 percent of total education budgets that local school districts spend to educate students with handicaps.[43]

Early Intervention Program for Infants and Toddlers (Title I of P.L. 99-457). The first piece of federal legislation to recognize families as the primary caregivers for children with handicaps, this federally funded program is a breakthrough in federal disability policy. The far-reaching legislation provides funding for states to create a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with handicaps and their families by October 1, 1991. The final federal regulations issued by the Department of Education on June 22, 1989, emphasize family-centered services rather than child-centered and agency-centered services and contain a strong mandate for community integration. The regulations state that, where appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps would participate. The program covers infants and toddlers from birth through age two if they are diagnosed as disabled or are determined to be at risk.

Federal Pre-School Program (Title II of P.L. 99-457). This act extends the rights and protections of the Education for All Handicapped Children Act to children with handicaps ages three to five by school year 1991-92. Just as the landmark Education for All Handicapped Children Act had a profound effect on persons ages five through 21, this recent act is expected to have a similarly significant impact on infants and toddlers.

Head Start. Project Head Start provides comprehensive developmental services to low-income preschool children. At least 10 percent of the enrollment must be children with handicaps.

QUESTION FIVE: WHAT STATE AND LOCAL SOURCES FUND SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES?

State Support

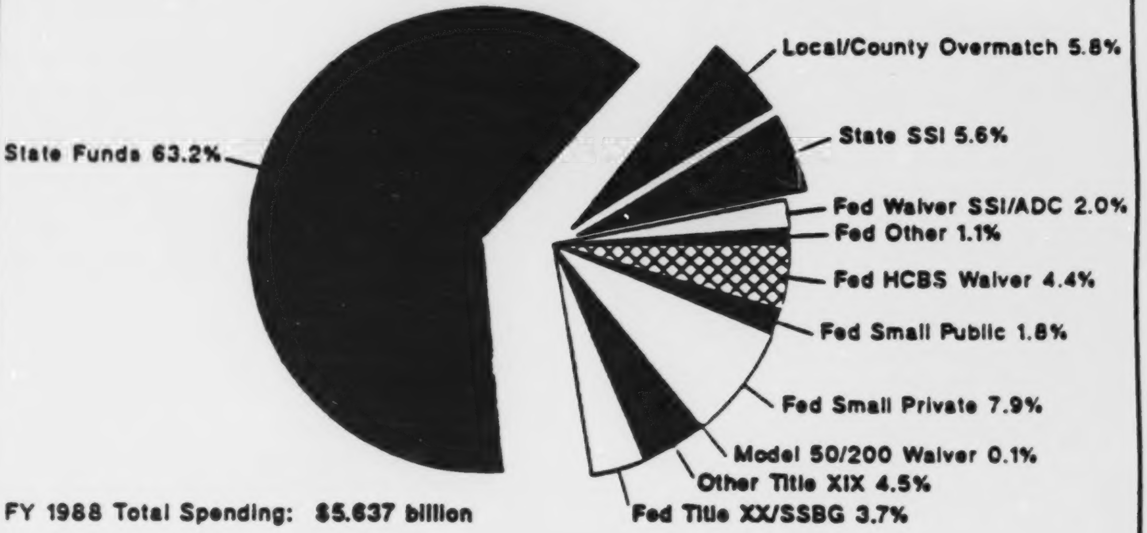
States are the centerpiece for providing and financing community services for persons with developmental disabilities. In addition to matching funds for many federal programs, states also provide 74.6 percent of the money for community services from state and local funds, amounting to $4.2 billion in 1988[44] (see Figure 1). The development of community services largely has been fueled by state initiatives. States also collectively spend slightly over one-half of their operating budgets on services to the more than 88,000 persons with developmental disabilities who still reside in state-operated residential facilities.[45] Further, states influence mental health financing by passing laws that regulate standards for public and private providers and third-party insurers.

Local Support

Many local governments provide matching funds to support services for persons with disabilities. Matching funds act as an incentive for local governments to raise local dollars and to participate in planning a cost-effective system of services for persons with developmental disabilities. In 1988, approximately 7.5 percent of the funding for community services was provided by local governments.[46] Funding for local/county services comprised more than 20 percent of total funding for community services in six states: Iowa, Kansas, Minnesota, Missouri, Ohio, and Virginia. Local or county funding was also a significant component of community resource spending in Arkansas, Illinois, Indiana, Michigan, Mississippi, Nebraska, Pennsylvania, Texas, and Wisconsin.[47]

Figure 1.

Community Services Revenue for Persons with Developmental Disabilities



FY 1988 Total Spending: $5.637 billion

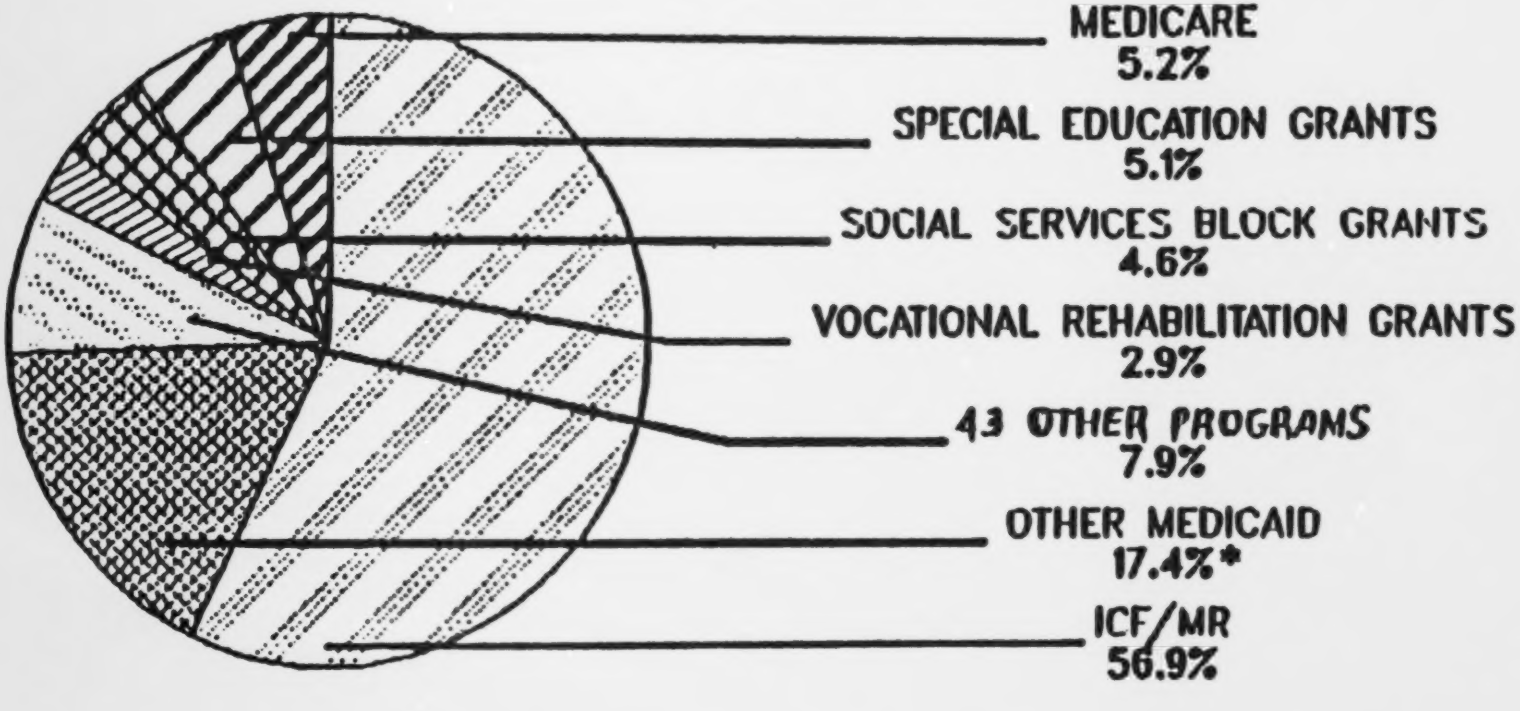
Source: Braddock et al., *The State of the States in Developmental Disabilities* (Baltimore: Brookes Publishing Company, 1989), p. 510.

Note: See the Glossary and Acronyms for definitions.

EXHIBIT A

FEDERAL SPENDING FOR MR/DD SERVICES
excluding SSI & SSDI

FY 1985 Total: $4.666 Billion



* Other Medicaid includes the following categories: Waiver programs 2.2%, day programs & personal care 2.5%, SNF/ICF 5.5%, & acute care 7.2%.

Adapted from Braddock, University of Illinois at Chicago, 1987.

ASPE120387-3P

APWA
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Fax Number 913/296-1158

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Commercial 307/777-7531
Fax Number 307/777-5402

October, 1990

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

JUL 15 1990

OFFICE OF SPECIAL EDUCATION PROGRAMS
CONGRESSIONAL NOTIFICATION OF GRANT AWARDS
Under The Hawkins - Stafford Elementary and Secondary School Improvement Amendments of 1988
(Formerly referred to as the P.L. 89-313 Program)

We are pleased to inform you that a total of $146,389,000 for fiscal year 1991 has now been allocated to State agencies on behalf of children with handicaps enrolled in schools operated or supported by those agencies. These funds are authorized under Section 1221 of Chapter 1, Title I of the Elementary and Secondary Education Act of 1965 as amended by the Hawkins - Stafford Elementary and Secondary School Improvement Amendments of 1988. A State listing of children counted and dollars allocated is enclosed for your information.

The amounts listed include local educational agency (LEA) programs for children with handicaps who have left State-operated or supported schools and are being educated in LEA special education programs.

Among the many ways in which these Federal funds may be used are the provision of enriched instructional services; employment and inservice training of teachers, teacher aides, and other project staff members; preschool services; workstudy programs; and parent counseling.

Additional information about this program for children with handicaps may be obtained from the coordinator for Chapter 1 (89-313) in your State educational agency or from Mr. William Tyrrell, Division of Assistance to States, Office of Special Education Programs, Washington, D.C. 20202; telephone: (202) 732-1025.

Your continued interest in this significant program for the education of children with handicaps is greatly appreciated.

Sincerely,

Robert R. Davila

Robert R. Davila
Assistant Secretary

Enclosure

400 MARYLAND AVE., S.W. WASHINGTON, D.C. 20202

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
OFFICE OF SPECIAL EDUCATION PROGRAMS
Hawkins - Stafford Elementary and Secondary School Improvement Amendments of 1988

State Operated Programs for Handicapped Children

FISCAL YEAR 1991

HANDICAPPED

ALLOCATIONS TO STATE AGENCIES

STATE	NUMBER OF CHILDREN	TOTAL ALLOCATION
NATIONAL TOTALS	268,364	$ 146,389,000.00
ALABAMA	858	358,287.00
ALASKA	3,024	1,894,159.00
ARIZONA	1,589	733,228.00
ARKANSAS	3,427	1,431,059.00
CALIFORNIA	4,179	1,970,083.00
COLORADO	5,067	2,813,936.00
CONNECTICUT	4,576	2,866,293.00
DELAWARE	2,863	1,754,595.00
DISTRICT OF COLUMBIA	3,140	1,966,818.00
FLORIDA	7,956	4,007,065.00
GEORGIA	2,911	1,225,887.00
HAWAII	1,132	548,532.00
IDAHO	456	190,418.00
ILLINOIS	46,209	24,727,529.00
INDIANA	9,699	4,562,539.0
IOWA	1,458	744,830

KANSAS	2,733	1,379,593.00
KENTUCKY	3,444	1,438,158.00
LOUISIANA	4,034	1,684,532.00
MAINE	1,213	636,227.00
MARYLAND	1,779	1,114,322.00
MASSACHUSETTS	17,601	11,024,831.00
MICHIGAN	13,349	7,684,939.00
MINNESOTA	387	210,321.00
MISSISSIPPI	856	357,451.00
MISSOURI	2,666	1,248,057.00
MONTANA	780	408,918.00
NEBRASKA	276	134,648.00
NEVADA	587	264,707.00
NEW HAMPSHIRE	1,784	986,227.00
NEW JERSEY	6,216	3,893,549.00
NEW MEXICO	252	113,576.00
NEW YORK	28,754	18,010,794.00
NORTH CAROLINA	2,519	1,051,893.00
NORTH DAKOTA	742	319,975.00
OHIO	8,612	4,262,359.00
OKLAHOMA	808	337,407.00
OREGON	10,527	6,218,657.00
PENNSYLVANIA	23,362	14,323,350.00
RHODE ISLAND	996	623,870.00

SOUTH CAROLINA	678	283,122.00
SOUTH DAKOTA	419	174,967.00
TENNESSEE	1,255	524,067.00
TEXAS	14,268	6,262,838.00
UTAH	2,451	1,023,497.00
VERMONT	2,728	1,708,752.00
VIRGINIA	1,319	677,988.00
WASHINGTON	4,010	2,059,688.00
WEST VIRGINIA	2,701	1,278,779.00
WISCONSIN	3,423	2,014,295.00
WYOMING	360	225,495.00
PUERTO RICO	975	225,004.00
GUAM	379	158,264.00
AMERICAN SAMOA	55	22,967.00
NORTHERN MARIANAS	62	25,890.00
VIRGIN ISLANDS	140	66,141.00
TRUST TERRITORY (PALAU)	320	133,627.00

Office of Special Education Programs
Part H Allocations

State	FY 1990 Allocation	FY 1991 Estimate
Alabama	$ 1,163,960	$ 1,714,148
Alaska	388,764	572,528
Arizona	1,249,449	1,840,045
Arkansas	677,333	997,498
California	10,061,348	14,817,208
Colorado	1,025,863	1,510,774
Connecticut	914,070	1,346,139
Delaware	388,764	572,528
District of Columbia	388,764	572,528
Florida	3,544,488	5,219,918
Georgia	2,031,998	2,992,495
Hawaii	388,764	572,528
Idaho	388,764	572,528
Illinois	3,445,848	5,074,652
Indiana	1,551,947	2,285,530
Iowa	723,365	1,065,289
Kansas	743,093	1,094,343
Kentucky	979,831	1,442,983

State	FY 1990 Allocation	FY 1991 Estimate
Louisiana	$ 1,400,698	$ 2,062,788
Maine	388,764	572,528
Maryland	1,440,154	2,120,894
Massachusetts	1,663,739	2,450,166
Michigan	2,702,755	3,980,309
Minnesota	1,288,905	1,898,152
Mississippi	789,125	1,162,134
Missouri	1,453,306	2,140,263
Montana	388,764	572,528
Nebraska	460,323	677,911
Nevada	388,764	572,528
New Hampshire	388,764	572,528
New Jersey	2,216,127	3,263,660
New Mexico	519,508	765,072
New York	5,273,988	7,766,929
North Carolina	1,854,445	2,731,015
North Dakota	388,764	572,528
Ohio	3,077,589	4,532,322
Oklahoma	894,342	1,317,085
Oregon	762,821	1,123,396
Pennsylvania	3,169,654	4,667,905
Rhode Island	388,764	572,528

State	FY 1990 Allocation	FY 1991 Estimate
South Carolina	$ 1,045,591	$ 1,539,827
South Dakota	388,764	572,528
Tennessee	1,348,089	1,985,312
Texas	5,786,920	8,522,316
Utah	683,909	1,007,183
Vermont	388,764	572,528
Virginia	1,782,108	2,624,486
Washington	1,407,274	2,072,472
West Virginia	427,443	629,489
Wisconsin	1,387,546	2,043,419
Wyoming	388,764	572,528
Puerto Rico	1,361,241	2,004,681
American Samoa	120,662	177,697
Northern Marinas	80,441	118,464
Guam	321,764	473,858
Virgin Islands	241,323	355,393
Palau	31,010	45,668
Secretary of the Interior	971,911	1,431,320
Total	79,520,000	117,108,300

Posted: Fri, Jul 20, 1990 10:40 AM EDT Msg: GGJA-4336-4963
From: SEP
To: DIRECTORS
CC: SEP
Subj: CHAPTER 1 CONGRESSG NOTIFICATION

OFFICE OF SPECIAL EDUCATION PROGRAMS
CONGRESSIONAL NOTIFICATION OF GRANT AWARDS
Under The Hawkins - Stafford Elementary and Secondary School Improvement Amendments of 1988
(Formerly referred to as the P.L. 89-313 Program)

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Sincerely,

Robert R. Davila
Assistant Secretary

Enclosure

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
OFFICE OF SPECIAL EDUCATION PROGRAMS
Hawkins - Stafford Elementary and Secondary School Improvement
Amendments of 1988

State Operated Programs for Handicapped Children

FISCAL YEAR 1991

HANDICAPPED

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PUERTO RICO	975	225,004.00
GUAM	379	158,264.00
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OFFICE OF
MATERNAL AND CHILD HEALTH

The Office of Maternal and Child Health was created October 1, 1987, but its roots go back more than 75 years to the Children's Bureau, established by Federal statute in 1912 to "investigate and report...upon all matters pertaining to the welfare of children and child life among all classes of our people." Among the issues the Bureau was instructed to look into were "the questions of infant mortality, the birth rate, orphanage, desertion...accidents and diseases of children...and legislation affecting children in the several States and territories." From these early inquiries flowed a wealth of information and new knowledge which influenced States to modernize their laws and encouraged the child health community to develop and improve services for mothers and children.

Title V of the Social Security Act, enacted in 1935, created the first Federal-State partnership in maternal and child health. Federal funds were provided for three types of work in the States: Maternal and Child Health Services, Crippled Children's Services, and Child Welfare Services. For the most part, the States provided the services which were paid for by a combination of Federal dollars and matching State dollars, and the Federal Government provided leadership to the program. Legislative and administrative changes in the program over the years allowed it to respond to significant changes in the Nation. Among these were the large numbers of women entering the workforce during World War II with the resulting need for day care programs for infants and children, development of new technologies which extended the lives of premature infants, medical advances in the treatment and prevention of handicapping conditions, the post-war trend to urbanization, and the shortage and maldistribution of skilled health professionals.

Another significant change to Title V came in 1981 with creation of the Maternal and Child Health Services Block Grant. In 1988, more than $525 million was appropriated for this program, 85 percent of which went directly to the States. With it, and their own resources, the States provide a variety of services from well-child clinics to family planning, immunizations to lead poisoning prevention, services for children with special health care needs, etc., which serve low-income and minority women and children and those who might have no other access to services.

The remainder, known as the Federal set-aside, is used by the Federal Government to support special projects of regional or national significance (SPRANS), which include research; training; hemophilia diagnosis and treatment; genetic diseases screening, counseling, and referral; and maternal and child health improvement project grants which demonstrate and test a variety of approaches intended to improve the health of and services delivery to mothers, infants, children, adolescents, and children with special health care needs. The Office of Maternal and Child Health also provides support for pediatric AIDS health care demonstration projects and for emergency medical services for children.

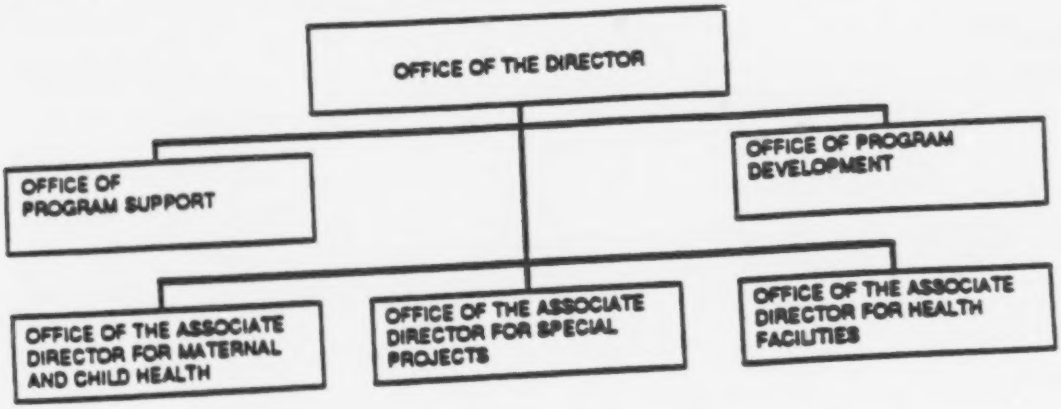
Maternal and child health improvement project (MCHIP) grants support projects which demonstrate how State and local agencies and organizations can improve the health status of mothers and children through the creative modification of their health care systems. For example, they may explore the effectiveness of outreach techniques, apply innovative methods to identify individuals at risk, develop early and effective intervention techniques, or more effectively use primary providers and specialty services. They may develop systems to gather, analyze, disseminate, and store data and information so as to increase their use by any part of the maternal and child health community. Successful methods developed by MCHIP grantees should be replicable elsewhere in the Nation.

The Office of Maternal and Child Health invites potential applicants to inquire about application requirements for the particular categories in which they are interested and then to make application for funding. Inquiries about possible grant support, technical assistance, or programmatic information should be addressed to the Director, Office of Maternal and Child Health, BMCHRD, HRSA, Room 9-11, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

In addition to providing grant support, the Office of Maternal and Child Health is exploring numerous efforts to improve maternal and infant health. For example, it is working closely with the Health Care Financing Administration in a shared goal of expanding eligibility and the availability of Medicaid funding for the care of women who are at risk of having low birthweight infants or other pregnancy complications. It is working with professional organizations to encourage provider participation in publicly-supported perinatal programs. The Office of Maternal and Child Health provides leadership in maternal and child health through its partnership with the State MCH Block Grant agencies, through the Federal grant programs, through its collaboration with other Federal agencies, and through its alliances with professional, voluntary and private organizations.

The wisdom gained from the projects and activities supported by the Office of Maternal and Child Health should be useful for the entire child health community and, when translated into prevention programs and comprehensive health services, should enhance and protect the health of mothers and children throughout the Nation.

BUREAU OF MATERNAL AND CHILD HEALTH AND RESOURCES DEVELOPMENT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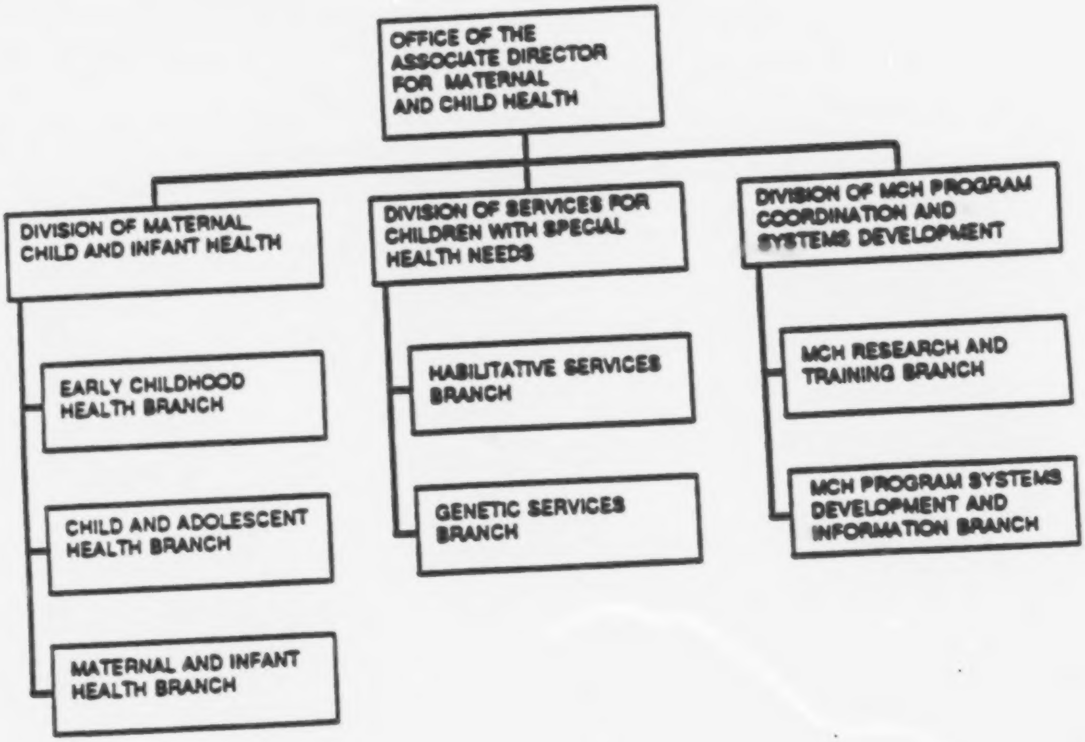
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Children's Home Health Network of Illinois
University of Illinois Division of Services
for Crippled Children
2040 Hills Meadows Drive
Suite A
Springfield, IL 62702
(217) 739-2340

MCJ-173363
07/01/85—06/30/88
Project Director:
Edward F. Lis, M.D.

PROBLEM: Ventilator-dependent children in Illinois are being considered for home discharge instead of continued hospitalization. The impact of this intensive home care on the health, developmental, and psychosocial needs of both the patient and his or her family is, by and large, unknown.

GOALS AND OBJECTIVES: The goal of the Children's Home Health Network of Illinois is to develop models of home health care for ventilator-assisted children and their families in Illinois in order to facilitate their discharge into the least restrictive environment which supports their health, developmental, and psychosocial needs.

METHODOLOGY: The system used to implement this program is: a) to review literature on related chronic conditions, complex medical technology, and home care; and b) to conduct an indepth exploratory survey and interview of parents, siblings and ventilator-dependent children, equipment vendors, physicians, nurses, home health agencies, and reimbursement providers.

EVALUATION: Evaluation will be based on outcome criteria and reported annually to OMCH.

EXPERIENCE TO DATE: The first year of the project was service-oriented and facilitated the discharge of five ventilator-assisted children to their homes. The second year was a year of transition and reorganization of staff and objectives. The third year has been oriented towards exploring the existing circumstances of pediatric home ventilation and the development of theoretical models, which address the limitations of the current process of pediatric home ventilation. The extension into the fourth year will consist primarily of the validation of the theoretical models and networking with the relevant health professionals, acute care facilities, and community resources which impact the lives of ventilator-dependent children and their families.

Ventilator-Assisted Care Program of Louisiana
Children's Hospital
200 Henry Clay Avenue
New Orleans, LA 70118
(504) 899-9511, ext. 509

MCJ-223289
07/01/83—06/30/88
Project Director:
A. Joanne Gates, M.D.

PROBLEM: When an individual requires long-term respiratory support through the use of a mechanical aid for breathing, for a period greater than three months because of chronic respiratory failure or insufficiency, that individual is considered to be ventilator-assisted. Ventilator assistance is an intervention designed to promote optimal growth and development. When medical stability is achieved while using the ventilator, intensive care is no longer necessary. Options to hospitalization, however, are neither encouraged financially nor inclusive of the support systems necessary for long-term commitments by home caregivers and community providers.

The Ventilator-Assisted Care Program (VACP) of Louisiana is funded by SPRANS . Three organizations founded the consortium: Children's Hospital, Handicapped Children's Services Program, and the Pediatric Pulmonary Center at Tulane Medical Center.

GOALS AND OBJECTIVES: The goals of the program have been to develop a model for care and services, develop and network service resources for ventilator-assisted individuals (VAIs), and coordinate education and training resources. The objectives have varied from year to year but have included activities designed to meet these goals as well as to provide for evaluation.

METHODOLOGY: During the current year, the organizational structure of personnel includes a full-time program coordinator and nurse consultant. The director, an interdisciplinary team of six other hospital-based staff, and a secretary are all part-time. In addition, there are two consultant medical co-directors to the project, an education consultant, and a data consultant. The Core Interdisciplinary Team (CIT) of professionals meets weekly. Ongoing activities of the CIT include continuation of model development, interdisciplinary problem-solving, training and education, and research design.

An advisory council of 16 members representing State, private, and consumer concerns meets monthly to address the full spectrum of service needs. Council members consider solutions to statewide impact regarding financial and liability questions; training, quality assurance, and service provision; residential and respite provisions, and other issues. The members have convinced the State of Louisiana Department of Health and Human Resources to implement a service contract to meet the needs of VAI's for case management, training and education, policy and advocacy, and respite and residential services. State policy development and advocacy have also been pursued through other formal linkages: the State Department of Education's Low Incidence Network, and the Louisiana Council on Developmental Disabilities' Group for Underserved Persons with Developmental Disabilities.

EVALUATION: Two evaluation projects are underway. The Center for Health Administration Studies (CHAS) at the University of Chicago is evaluating all three SPRANS for ventilator users. The VACP provides annual site visits and attends executive and advisory meetings. Regular contact with CHAS is maintained. Reports of project activities are submitted quarterly, as requested. The recruitment of family participants in the national study has resulted in participation of about 60 percent of the Louisiana population. The internal program evaluation has been operative for two years measuring outcome (family stress, satisfaction, home care preparation, and community involvement), and costs of care. Of the 43 families followed, 35 are involved as volunteers in the study.

EXPERIENCE TO DATE: The program has worked with 43 families. The population has increased over 400 percent since the time of the original proposal. The VACP model of care and services developed over the last three years emphasized coordinated, interdisciplinary management of the many issues and phases of hospitalization, in order to reduce length of stay (LOS) and subsequent costs in financial and human resources. The LOS was associated with time required for medical stabilization, discharge planning, family and caregiver training, and sometimes, medical placement. The LOS for this population averaged 155 days per admission. This figure was based on the records of hospital admissions for 20 VAIs from 1978 to June 1985. More recent information on hospitalizations within the third VACP year (July 1, 1985 to March 31, 1986) demonstrated that 49 hospital stays were required by Louisiana's VAIs and the average LOS during that period was reduced to 26 days for discharged patients. The 83 percent reduction in the average LOS was a significant decrease.

In total, 114 formal training sessions were provided by VACP personnel during the first three years. Audiences included: MCH and Title V personnel, educators and related school personnel, health care professionals (both hospital-based and community-based), and others in-State and out-of-State. Training of preservice professionals at Children's Hospital included training of service providers of VAIs. At Children's Hospital during the first 3 years, families of 20 VAIs were trained to take their child home, and personnel at residential settings were trained for 2 VAIs requiring placement. The VACP staff served as consultants to other hospitals to promote three additional discharges to home. The VACP has worked successfully to mainstream VAIs into academically appropriate classrooms, summer camp, and other community-based activities.

The VACP developed and disseminated many training materials. The volume, *Homeward Bound: Resources for Living at Home with a Chronically Ill Child* was written and disseminated nationally during year three. The volume was designed for parents and other community care providers, but has also been used as a model for developing local information in other States. Specific VACP materials were included in S. Kleinberg's training volume, *Alternatives to Hospital Care for Respiratory-Disabled*, published by MCH for national adaptation. Seventy-minute videotapes developed to train providers of respiratory skills in home care will be marketed during year four. The program's current publications in professional journals now number four, and several are in development.

Neither a system of case management nor adequate service in case management has been available for this population in Louisiana. The VACP Office has remained involved with families post-discharge, providing assistance to work through problems and issues in engaging/maintaining services. Medicaid has now approved funding for VAIs in an optimal service package of case management, which will be provided through the VACP. Families relied on the VACP for information regarding care, service issues, and referrals. The toll-free information line has been a very successful activity.

Our philosophy has been to support family involvement with other families for the accomplishment of interpersonal support, shared information regarding case management issues, advocacy, and project consultation. Efforts to encourage parent-to-parent support included: a) an informal network for parent-to-parent contact; b) the coordinator's consultation to national SKIP (Sick Kids Need Involved People); and c) a new, generic, parent support program at Children's Hospital, the Education and Support Program (ESP), as a hub for several disease-specific parent groups involving SKIP of Louisiana, as well.

The program has generated ideas and interests for the development of other local programs (MCH or otherwise funded) to meet the needs of children and adolescents with complex medical needs, and it works in cooperation with these programs to carry out our mutual goals.

A Model for Home and Community Care for Children Who Are Technology Assisted
Coordinating Center for Home and Community Care (CCHCC)
P.O. Box 613
Millersville, MD 21108
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MCHIP
MCJ-245023
10/1/87—6/30/90
Project Director(s):
Joanne Kaufman

PROBLEM: The dramatic medical advances enabling children with complex medical needs to remain alive have been widely documented. Considerable professional and public attention has been devoted to recent innovations that have supported the initial survival and continued progress of children who are assisted by technology.

The social and economic consequences of these innovations have been and continue to be debated by health care planners and policymakers. These advances in medical technology and changes in health care policy have enabled children who are technology assisted, and have historically remained in hospitals, to receive care at home. Dilemmas in finding a balance between attempting to integrate the child with chronic illness into the family while maintaining intensive levels of medical care at home have stimulated discussion regarding family-centered, comprehensive care in the community.

As some children are assimilated into their families and policies begin to be refined, an additional tier of issues arises concerning:

1. Public-private collaboration for financing care at home;
2. Education of professionals and families in family-centered, community-based care management; and
3. Options for those children who are medically stable, but for whom the biological parents' home is not an option.

GOALS AND OBJECTIVES: The goals of the program are to:

1. Develop a model for public-private sector collaboration in the financing and application of medical care management services, in order to achieve maximum health benefits at home in a cost-efficient manner;
2. Develop a methodology for educating professionals in supporting and utilizing family-centered, comprehensive case management in order to maximize care for children with special health needs;
3. Identify and analyze the most desirable options to the almost exclusive reliance on hospitalization and the child's biological family's home for care of the child with medically complex needs in order to maximize the child's growth, development, and health potential in the least restrictive setting; and
4. Continue providing family-centered case management services to children funded by both Medicaid and by third-party payers in order to maximize normalized psychosocial adaptation to home, growth and development, and physiologic stability.

METHODOLOGY: The Coordinating Center for Home and Community Care is exploring four directions in addressing these concerns. CCHCC is refining the public-private funding mix for delivery of case management services and other needed services, educating professionals in supporting and utilizing family-centered, comprehensive case management, analyzing alternatives to exclusive reliance on a hospital or the child's biological parents' home for care, and continuing to provide quality-assured, cost-effective, and family-centered care management.

EVALUATION: The evaluation plan for this project involves both process and outcome evaluations. The plan for process evaluation involves the monitoring of project objectives and action steps. Each objective and action step has associated performance indicators and timelines. Monitoring how these objectives are met within the established timelines constitutes the process evaluation.

Broad evaluation objectives of the project are to:

1. Determine whether tasks and activities have been completed according to the project timelines;
2. Document the number and types of technology-assisted children in Maryland, as well as the types of services they require, on a county-by-county basis ;
3. Document the utilization and cost-effectiveness of the case management model;
4. Produce a published document describing best choices for community living alternatives for families and their children when the biological family's home is not an option;
5. Document the procedures and methodology used to create the comprehensive model for private/public collaboration in financing services for children who are technology assisted; and
6. Document the need for step-by-step protocols for training families in home care medical management over time.

EXPERIENCE TO DATE: The CCHCC staff assisted the Maryland Assistance Program and Children's Medical Services in writing the renewal of the original model waiver and an application to HCFA for an additional technology-assisted waiver.

The CCHCC conducted a survey of 25 major insurance providers, requesting information on those companies with existing case management practices with an emphasis on children. Responses from the survey have been annotated.

The CCHCC has task-analyzed home visit protocols used by the CCHCC clinical care coordinators, including the first 48 hours after discharge, the weekly visits for the first month after discharge, the biweekly visits for the second month after discharge, and monthly visits thereafter for 3 months.

The CCHCC, in conjunction with the Office of Maternal and Child Health and Georgetown Child Development Center, identified a panel of experts interested in designing a comprehensive model of community living alternatives for children. The CCHCC conducted a literature search and program review of the array of service options and produced a preliminary bibliography. The CCHCC convened the panel of experts for a 1-day "think tank" to discuss options, policy, barriers and constraints, and the methods to overcome those barriers and constraints.

The CCHCC is presently providing case management services for 86 children. Children served are funded through the Maryland Medical Assistance Model Waiver Program, the Maryland Technology-Assisted Waiver, and through private third-party payers.

The CCHCC is also providing assessment and evaluation services for long-term care planning and cost analyses for insurance carriers who insure children who have experienced a catastrophic event.

C. Other Information Support

1. Overview of RESNA National Technical Assistance Project.

RESNA

RESNA Technical Assistance Project
Suite 700, 1101 Connecticut Avenue, N.W., Washington, D.C. 20036
202/857-1140 Voice/TDD, FAX: 202/223-4579

RESNA, an interdisciplinary association for the advancement of rehabilitation and assistive technologies, has been awarded a contract by the National Institute on Disability and Rehabilitation Research (NIDRR). The purpose of this contract is to provide technical assistance and information to States on the development and implementation of a consumer-responsive statewide program of technology-related assistance under the Technology-Related Assistance for Individuals with Disabilities Act of 1988 (P.L. 100-407). The purpose of this act is to provide discretionary funds to States on a competitive basis to develop such a system.

States currently receiving funding under P.L. 100-407 are:

Alaska
Arkansas
Colorado
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Massachusetts
Minnesota
Mississippi
Nebraska
Nevada
New Mexico
New York
North Carolina
Oregon
Tennessee
Utah
Vermont
Virginia
Wisconsin

NIDRR will be funding additional states each year. It is hoped that all 50 states and territories will be funded by 1995.

This contract provides RESNA the resources to:

- Develop technical assistance plans for the States receiving funding under P.L. 100-407;
- Produce a directory of expert consultants in assistive technology services;
- Publish a newsletter *A.T. Quarterly*, and other written materials on the delivery of assistive technology services;
- Provide States access to an electronic bulletin board designed to share information among states and interested parties;
- Design an evaluation package to analyze States' progress towards the development of a consumer-responsive assistive technology delivery system;
- Host three meetings especially designed to meet the needs of States as they develop their state systems;
- Bring together an office of professionals in the area of assistive technology who can provide on-going support to States and individuals;
- Organize a library of information which will foster the development of assistive technology services; and
- Provide technical assistance to states and other interested parties through visits, telephone or by mail on developing consumer-responsive systems of assistive technology.

Please feel free to contact our office if we can be of assistance to you.

an interdisciplinary association for the advancement of rehabilitation and assistive technologies

RESNA
TECHNICAL ASSISTANCE
PROJECT

OUTLINE OF FEDERAL LAWS AND RULES

MEDICAID
SPECIAL EDUCATION
VOCATIONAL REHABILITATION

JANUARY 1991

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WASHINGTON, D.C. 20036
202/857-1140

OUTLINE OF FEDERAL LAWS AND RULES

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INTRODUCTION

This is an outline of the federal laws and rules that define three programs: Medicaid, special education (including early intervention), and vocational rehabilitation. These three programs are the principal sources of federal support for assistive technology funding. This outline identifies and interprets specific sections of the laws and rules that are resources for assistive technology funding.

Understanding the scope of these laws and rules is essential. Every state participates in these programs, and therefore, must follow these federal criteria. In addition, each program requires states to submit a "state plan" that follows federal program criteria in exchange for federal financial assistance. They also must be reviewed and understood.

Reading and understanding this outline cannot substitute for reading the applicable laws, rules, and state plans. Instead, the outline is merely a tool to aid a careful and comprehensive review of the Medicaid, special education, early intervention, and vocational rehabilitation programs operating in each state.

Public Law 100-407, the Technology Related Assistance for Individuals with Disabilities Act requires that these programs be reviewed. The "Tech Act" presents two formidable challenges to the State and Federal governments. Congress recognized that assistive technology devices and services have enormous potential to improve the lives of individuals with disabilities. Congress also recognized that access to assistive technology is frequently blocked because of a lack of resources; of trained personnel to determine the need for technology; of information about its potential; and of coordination among state and federal programs that may provide assistive technology funding. The Tech Act's two challenges are first to identify these barriers, and then to eliminate them.

This outline will assist states funded under the Tech Act to meet both challenges in relation to assistive technology funding: barrier identification and removal. First, it provides a means to identify funding barriers by supplying a standard -- the federal laws and rules -- against which state and local laws, rules, interpretations and practices can be measured. A comparison will result in the identification of state- or locally- created assistive technology funding barriers; i.e., those state laws, rules, interpretations and practices that create funding barriers where the corresponding federal laws and rules support funding.

Second, the outline will aid state Tech Act staff's efforts to remove and/or overcome these state level funding barriers. By providing information about the full scope of each program in relation to assistive technology funding, Tech Act staff can negotiate the formal elimination of the barriers with responsible state and local government agencies and/or the state legislature. Alternately, through public education and recruitment and training of advocates (another mandatory responsibility of Tech Act staff), these barriers can be overcome through advocacy.

SECTION I

OUTLINE OF THE MEDICAID ACT & RULES

I. OVERVIEW

* Medicaid is the largest and perhaps the most important source of public funding for assistive technology for many individuals with disabilities.

* The Medicaid program was established in 1965 when Title XIX was added to the Social Security Act. (42 U.S.C. Section 1396 *et seq.*; 42 C.F.R. Parts 430 to 456).

* Medicaid is one example of "cooperative federalism," in which the federal and state (or federal, state and local) governments share responsibilities for providing benefits to the poor, in this case: medical assistance. The federal government sets general program criteria, and provides financial assistance to the states. The states, or state and local governments, are responsible to administer the program, and meet part of the program's costs.

* Medicaid will not directly supply medical services or a cash grant to recipients. Instead, it operates by providing reimbursement to providers of covered medical equipment, services and supplies to eligible persons. Emphasis is added because not all medical services are included, and not all poor persons are eligible. State plan requirements pertaining to individual eligibility and scope of coverage are discussed below.

II. STATE PLAN REQUIREMENTS

* States must choose to participate in the Medicaid program. They do so by submitting a state medical assistance plan to the Health Care Finance Administration within the U.S. Department of Health & Human Services that meets criteria established by the federal government. (42 U.S.C. Section 1396a(a)).

* The state plan must include more than four dozen provisions. Of greatest importance is that the plan assure that the Medicaid program be administered on a state-wide basis (Section 1396a(a)(1)); designate a single state agency which will be responsible for administration of the program (Section 1396a9a(5)); that persons eligible for services have freedom of choice in the selection of their care or service provider (Section 1396a(a)(23)); and that it provide an opportunity for individuals to challenge the denial of eligibility or coverage or the failure to make decisions in a timely manner (Section 1396a(a)(3)). The state plan also must provide assurances regarding the state's financial contribution to the program, and identify the services, both mandatory and optional that will be part of the state's Medicaid program.

- If approved by the Secretary of HHS, the state becomes eligible to receive federal financial assistance to meet the costs of the program outlined in the state plan (42 U.S.C. Section 1396a(b)). The federal government's share is between 50 - 80 percent of the state's total costs, based on the state's per capita income (42 U.S.C. Section 1396b(a)(l); 1396d(b)). The state, or the state and local governments, must supply the balance of the program's costs (20 to 50 cents of each dollar of Medicaid costs). See Chart on the following page which lists the federal share of each state's costs.

- Despite the large number of federal program criteria, the states retain extraordinary control over the operation of their Medicaid programs. This control includes whether to participate at all; what services beyond the mandatory minimum to cover; which groups of persons to include; enrollment of and reimbursement rate setting for providers; all eligibility and coverage decisions; and the administrative process for reviews of eligibility and/or coverage denials. In addition, there are minimal requirements imposed on the states when they seek to change their state plans, whether to increase or decrease coverage.[1]

- The state plan is an important document to review. First, it must be reviewed in terms of the federal program criteria: does it in fact comply with them? Second, the state plan must be compared with the state's day to day administration of the program: does the state in fact comply with the plan, i.e., the promises it made to the federal government in exchange for federal financial assistance?

III. INDIVIDUAL ELIGIBILITY CRITERIA

- Under federal law, there are four groups of poor people who may be eligible for Medicaid services. One group, the "categorically needy," must be eligible for services, according to the federal law. The other three groups, known as the "optional categorically needy," "medically needy," and "waiver" populations are made eligible if the states exercise options made available in the federal law. Each group may include a different population, and may be eligible for different Medicaid services. (Services eligibility and scope are described in Section IV.)

- The four groups all but defy simple description. They are defined in an almost impenetrable mass of words and numbers found at 42 U.S.C. Section 1396a(a)(10); 42 C.F.R. Part 435. In general, they consist of two groups: families with children; and the aged, blind and disabled.

---

[1] By being able to control provider enrollment and reimbursement rates, Medicaid's "statewideness" requirement may be a promise unfulfilled. Care may be stated on the state Medicaid plan, but not be available or accessible because no provider is willing to offer the service at the state-set reimbursement rate. In other circumstances, some providers do exist, but they are unable to provide all the needed care to all the eligible persons.

Provider licensure and reimbursement rate are valid issues for Tech Act staff and advocates to explore where services are unavailable to large numbers of persons.

- *OBRA-87*. The Omnibus Budget Reconciliation Act of 1987 requires nursing homes that receive federal funds to place residents with disabilities who do not require 24-hour nursing in less restrictive settings. Question Seven addresses this issue.
- *Medicaid Technical Amendment of 1988 within P.L. 100-146*. States have the option to include special education-related services under P.L. 94-142 and early intervention and family support services under P.L. 99-457 in their state Medicaid plan in order to receive federal matching funds. These two federal laws are described in this question under "Education."

Table 1.

Federal Medicaid Matching Rate for Medical Assistance by State (FY 1990)

State	Rate	State	Rate
Alabama	73.21	Nebraska	61.12
Alaska	50.00	Nevada	50.00
Arizona	60.99	New Hampshire	50.00
Arkansas	74.58	New Jersey	50.00
California	50.00	New Mexico	72.25
Colorado	52.11	New York	50.00
Connecticut	50.00	North Carolina	67.46
Delaware	50.00	North Dakota	67.52
Florida	54.70	Ohio	59.57
Georgia	62.09	Oklahoma	68.29
Hawaii	54.50	Oregon	62.95
Idaho	73.32	Pennsylvania	56.86
Illinois	50.00	Rhode Island	55.15
Indiana	63.76	South Carolina	73.07
Iowa	62.52	South Dakota	70.90
Kansas	56.07	Tennessee	69.64
Kentucky	72.95	Texas	61.23
Louisiana	73.12	Utah	74.70
Maine	65.20	Vermont	62.77
Maryland	50.00	Virginia	50.00
Massachusetts	50.00	Washington	53.88
Michigan	54.54	West Virginia	76.61
Minnesota	52.74	Wisconsin	59.28
Missippippi	80.18	Wyoming	65.95
Missouri	59.18	District of Columbia	50.00
Montana	71.35	Puerto Rico	50.00

Source: U.S. Department of Health and Human Services, December 1989.

A. Categorically Needy

* Congress presumed that certain "categories" of people will be unable to meet the costs of their medical care needs. The Medicaid Act requires states to make these "categorically needy" people eligible for services. The Act states further that states must offer a minimum list of medical services to categorically needy persons.

* The categorically needy meet the family characteristics and financial standards set forth in one of two federal cash benefits programs. In general, mandatory Medicaid eligibility is required for two groups: families with children, and the aged, blind, and disabled.

1. Families with Children:

* recipients of Aid To Families With Dependent Children ("AFDC") cash assistance;

* persons who are not receiving AFDC because of small income or recourse issues but who otherwise would be eligible;

* children receiving adoption assistance or foster care maintenance payments under the Child Assistance & Child Welfare Act of 1980 (Title IV-E of the Social Security Act);

* as of April 1, 1990, pregnant women and children under age 6 with incomes not greater than 133 percent of the federal poverty rate. Children covered under this provision are entitled to all Medicaid services; coverage for pregnant women may be limited by the states to prenatal care, and all pregnancy related care through delivery.

2. Aged, Blind & Disabled:

* recipients of Supplemental Security Income (SSI) disability benefits, although some states, known as "209(b)" states, do not automatically offer Medicaid upon SSI eligibility. Instead, they may apply a somewhat stricter disability test. [2]

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[2] The 209b states are:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Utah
Virginia

B. Optional Categorically Needy

* The Medicaid Act allows states the option of increasing the groups of persons who may be considered "categorically needy." This option grants states the opportunity to incrementally increase the scope, and concurrently, the cost of their Medicaid programs. If included in the state plan, these additional groups will become eligible for the same services as the categorically needy (42 U.S.C. Sections 1396a(a)(10)(A)(ii); 1396a(e)).

* There are now eleven groups of persons who may be considered "optimally categorically needy." Common to all is that they meet the AFDC and/or SSI program criteria (e.g., single women with children; aged, blind or disabled), but have family characteristics that make them ineligible for cash assistance provided by these programs. Thus, they may be as poor, and as unable to meet the cost of their medical care needs as the categorically needy, but they do not "fit" those programs' eligibility criteria.

C. Medically Needy

* The Medicaid Act also allows states the further option of expanding their Medicaid programs to include groups of persons who may meet the family characteristics of the categorically needy programs, but who cannot meet the strict financial limits on income and resources imposed by those programs.

* Because these people are viewed as having "excess" income, the federal law allows states to impose a "spenddown," a form of "deductible." The medically needy may be required to incur some medical costs prior to becoming eligible for Medicaid.

* In addition, the states have the option of offering different Medicaid services to the medically needy than they do to the categorically needy (42 U.S.C. Section 1396a(a)(10)(C)).

D. Waivers

* The Medicaid Act's most flexible eligibility option is a waiver. This option allows states to secure federal approval to "waive" certain program requirements, such as financial needs tests, statewideness, or provider freedom of choice.

* Waivers may target specific groups of individuals as well as specific services. Common to all, however, is that the waivers must be shown to allow individuals or groups of persons (such as technology dependent children) who would otherwise be eligible for institutional care to remain in the community; or who are currently in an institutional setting to be discharged to the community (42 U.S.C. Section 1396n).

* OBRA in 1981 authorized the Home and Community Board Services Waiver Program. Case Management and an array of support services to maintain an individual with mental retardation or related conditions (cerebral palsy, epilepsy, autism) in a

community living situation are authorized under this waiver program. Long term supports to sustain a supported employment situation and assistive technology devices and services are also reimbursable under this waiver program sometimes referred to as the "2176 waiver". Federal support for 2176 waivers grew from $1.25 million in FY 1983 to $248 million in FY 1988. As of 1988, 36 states offered services to over 29,000 individuals with developmental disabilities through this program.

* A second type of waiver option for states is the Medicaid Model Waiver Program. Similar in purpose to the Home and Community Based Waiver, this program allows Medicaid coverage at home for ventilation dependent children in order to avoid care in an institutional setting at an equal or higher cost. Technology devices and services are authorized for reimbursement under this waiver program. The Model Waiver sometimes referred to as a Katie Beckett Waiver tends to have a narrow eligibility criteria. However, it remains a viable option for pursuit by states seeking to expand family support options in the home for children with severe multiple disabilities.

* Waivers have significant potential to assist individuals with disabilities avoid unneeded institutional care, and to assist states redirect their Medicaid costs. Barriers to their use include a failure by state Medicaid agencies to aggressively seek waivers, and extraordinary bureaucratic barriers imposed by federal officials.

IV. SERVICES

* The Medicaid Act lists mandatory services, which must be provided by the states to the categorically needy. These services define the minimum Medicaid program the states may operate. The federal law also states a long list of optional services, which if included in the state plan will be eligible for federal reimbursement (42 U.S.C. Section 1396d; 42 C.F.R. Parts 440.; 441.; 442).

A. Mandatory Services for the Categorically Needy

* The Act lists 11 services that states are required to provide as a condition of participation in the Medicaid program. These services must be made available to the categorically needy, and if included in the state plan, the optional categorically needy. The mandatory services constitute basic medical care, including:

- inpatient hospital care;
- outpatient hospital care;
- laboratory & x-ray services;
- skilled nursing facility services for persons over age 21;
- family planning services and supplies to individuals of child bearing age;
- physicians' services;
- nurse midwife services;
- home health services, including medical supplies & equipment;

- early, periodic screening, diagnosis & treatment for persons less than 21;
- rural health clinic services
- services to pregnant women

(42 U.S.C. Section 1396a(a)(10)(A)).

B. Optional Services:

* In addition to these mandatory services, the Act lists more than 30 additional services that states may choose to include in their Medicaid programs. These include:

- Podiatrists' Services
- Optometrists' Services
- Chiropractors' Services
- Other Practitioners' Services
- Private Duty Nursing
- Clinic Services
- Dental Services
- Physical Therapy
- Occupational Therapy
- Speech, Hearing & Language Therapy
- Prescribed Drugs
- Dentures
- Prosthetic Devices
- Eyeglasses
- Diagnostic Services
- Screening Services
- Preventive Services
- Rehabilitation Services
- Services for Persons Age 65 or Older in Mental Institutions
- Intermediate Care Facility Services
- Intermediate Care Facilities for MR/DD Persons
- Inpatient Psychiatric Services for Persons Under Age 22
- Christian Science Schools
- Skilled Nursing Facilities for Persons Under Age 21
- Emergency Hospital Services
- Personal Care Services
- Transportation Services

(42 U.S.C. Section 1396d).

V. WHAT MAKES MEDICAID A RESOURCE FOR ASSISTIVE TECHNOLOGY FUNDING ?

A. Introduction

- The Medicaid Act can and should be viewed as the principal source of public funding for assistive technology devices and services. It is one of the largest programs in the federal budget, and one of the largest components of every state budget.

- Medicaid also must be provided without limits set by appropriations. Unlike most programs whose appropriations are express limits on spending, for Medicaid, these are merely best guesses by the Congress and state legislatures. Eligible persons may access covered services, and providers may provide them without fear that reimbursement will be denied by one of Medicaid's funding partners. None can deny their share of reimbursement because the "cupboard is bare," or the "appropriations have been exhausted." [3]

- Another factor is that Medicaid is comprehensive in scope, with no express assistive technology funding barriers for persons who are eligible. Funding barriers in the Medicaid program arise more from the lack of understanding about the proper scope of the Act, and from the lack of advocates capable of forcing the program to meet its full potential.

B. Reviewing Statutory & Regulatory Terms

1. General Program Criteria Supporting Funding

- The Medicaid Act contains four general concepts that should be viewed as supporting assistive technology funding:

"Rehabilitation"   "Amount, Duration & Scope"

"Best Interest"   "Diagnosis Based Decision Making"

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[3] The "unlimited" or entitlement nature of the Medicaid program should be reviewed carefully when funding decisions are made for assistive technology. In many cases, state officials can choose to secure the technology from one of two or three programs (e.g., Medicaid, vocational rehabilitation, special education) with overlapping eligibility criteria.

Simply opting for the program with the highest federal reimbursement rate is not always the most fiscally responsible choice. Vocational rehabilitation, for example, may have a higher federal reimbursement rate (75%), but it is one thirtieth the size of Medicaid. Also, unlike Medicaid, vocational rehabilitation services will be limited by their appropriations. Thus, state program administrators seeking a funding source for assistive technology must decide whether it is more cost effective to save a few state dollars by using far more scarce federal vocational rehabilitation services, rather than allowing those funds to be put to other uses.

2. General Program Criteria Perceived As Funding Barriers

- The Medicaid Act also contains two general concepts that are perceived as funding barriers:

"Medical Need"
"Prior Approval" or "Authorization"

3. Specific Medicaid Services Supporting Funding

- Finally, there are nine Medicaid services that can be viewed as assistive technology funding resources:

"Rehabilitative Services"
"Preventive Services"
"Prosthetic Devices"
"Durable Medical Equipment"
"Occupational Therapy"
"Physical Therapy"
"Speech-Language Therapy"
"Early, Periodic Screening, Diagnosis & Treatment"
"Intermediate Care Facility Services"

Each of these terms is described below.

a. Rehabilitation

- Congress established Medicaid:

> For the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish . . . (2) rehabilitation and other services to help [eligible] families and individuals attain or retain capability for independence or self care, [and that] there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted and had approved by the Secretary, State plans for medical assistance (42 U.S.C. Section 1396).

- The term "rehabilitation" is the single most important word in the Medicaid Act in regard to assistive technology funding.

* By including "rehabilitation" as one of the two purposes of the Medicaid Act, it should be interpreted as a distinct goal of the Act, i.e., one that is incorporated into every Medicaid service.

* Rehabilitation is the process of restoration of functional ability or of functional improvement. As a purpose of the Act, affecting every Medicaid service, this means that every service should be provided in a manner that allows recipients to improve their functioning.

* In addition, the Act provides the measure of how much improvement should be supported by Medicaid services, i.e., how much rehabilitation must occur. The Act should be interpreted to support the provision of each service in a manner that will permit the achievement of independence or self care, or the highest level of individual functioning short of independence or self care.

* With this interpretation given to the term "rehabilitation," it is easy to see how Medicaid will be a major source of funding for assistive technology. The Medicaid Act is a program designed in part to improve the functional abilities, and enhance the lives of individuals with disabilities.

* Assistive technology, as Congress recently acknowledged in the Tech Act, has enormous potential to enable those goals to be realized.

* One caveat: Section 1396 is an appropriations section. Generally such provisions are not interpreted as sources of mandatory program criteria. However, the rehabilitation goal of the Medicaid Act is not stated only in this section: other provisions carry the rehabilitation goal to all Medicaid recipients and to all Medicaid services.[4]

b. Best Interests

* One of the many assurances states must include in their state plans as a condition of Medicaid program participation is to

> provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients; (42 U.S.C. Section 1396a(a)(19)).

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[4] The rehabilitation goal also may be stated in the state law creating the state medical assistance program. In New York, for example, the term "medical assistance" is defined as

> payment for part or all of care, services and supplies necessary to prevent, diagnose, correct or cure conditions of the person that cause acute suffering, result in illness or infirmity, interfere with capacity for normal activity, or threaten some significant handicap. . . .(New York Social Services Law, Section 365-a(2)).

- The "best interests" assurance extends the congressional goal of rehabilitation to all Medicaid recipients. Medicaid services must enable recipients to achieve independence or self care, because such improvement most assuredly would be in the recipients' best interests. Assistive technology must be provided by Medicaid to satisfy this requirement. By contrast, states may not restrict services such that a level of independence or self care cannot be achieved, because such a restriction could not be in the recipients' best interests.

c. Amount, Duration & Scope

- The Medicaid Act does not direct states to provide any precise amount, frequency or intensity of services. Instead, state plans must assure that

> Each service must be sufficient in amount, duration and scope to reasonably achieve its purpose. (42 C.F.R. Section 440.230(b)).

- The "amount, duration & scope" provision complements the "best interests" assurance by extending the congressional goal of rehabilitation to all Medicaid services, including those that will support assistive technology.

- Rehabilitation is one purpose for which every Medicaid service is provided; therefore, each must be provided in sufficient amount, duration, and scope to allow recipients to reasonably achieve that goal. If assistive technology is needed to achieve that goal, it too must be provided. [3]

d. "Diagnosis Based Decision Making"

- A third assurance states must provide as a condition of Medicaid participation is that there will be no denials of services because of "diagnosis based decision making."

> The Medicaid agency may not arbitrarily deny or reduce the amount, duration & scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition. (42 C.F.R. Section 440.230(c)).

- Although this requirement states that it is applicable only to "required" services, it has been applied to optional services as well.

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[3] One caveat: Medicaid operates to provide services to eligible persons, but it does not guarantee a particular scope of care or services to any one individual. For example, the "amount, duration & scope" provision does not prohibit states from setting numerical limits on coverage for in-patient hospital treatment, or conceivably, to other services as well. However, this provision will protect individuals by requiring states to show that their limitations will still enable most of the persons who will need the service to achieve its goals. For this reason, the "amount, duration & scope" provision is a valuable tool to challenge limits on services that cannot be supported by a comprehensive state-wide review of recipients' needs.

- The prohibition on diagnosis based decision making is a particularly valuable tool to ensure that states do not attempt to limit assistive technology because it is perceived to be too costly. Often the limits are explicit: states may omit technology from lists of covered services, or add technology to lists of non-covered services. This provision may be used to strike down lists of covered or non-covered items which exclude coverage for assistive technology. [8]

e. Medical Necessity and Utilization Control

- Yet another assurance required as a condition of participation in the Medicaid program is that the states

> provide such methods and procedures relating the utilization of, and payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services . . . .(42 U.S.C. Section 1396a(a)(30)(A)).

- This assurance is re-stated in the federal Medicaid regulations as follows:

> The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. (42 C.F.R. Section 440.230(d)).

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[8] Maine, for example, places augmentative communication devices on a list of non-covered services. New Hampshire presently is considering such an exclusion. At the same time, however, both states provide speech and language therapy as part of their Medicaid programs. Kentucky, by contrast, offers augmentative communication devices only to persons with mental retardation, while California denies these devices to persons with cancer.

These distinctions: covering speech and language therapy but not augmentative communication, or limiting coverage to persons with specific impairments amounts to diagnosis, type of illness or condition based coverage in violation of the Act. The confirmation of this conclusion is that the Oregon Medicaid program, which had similarly excluded communication devices while covering speech pathology, settled a lawsuit challenging the exclusion. These devices were added to the Oregon Medicaid program in July 1990.

Augmentative communication devices are appropriately seen as supplies and equipment used in speech/language therapy (42 C.F.R. Section 440.110(c)(1)). For this reason, by denying coverage for these devices, these states deny speech and language therapy to an entire class of persons, which may be identified by diagnosis or type of illness (e.g., persons with severe cerebral palsy, or who experienced a stroke or traumatic injury), or by condition (e.g., persons with the most severe disabilities, whose ability to communicate by manual or verbal means is insufficient, and who must rely on an augmentative communication device to meet their communication needs).

Similar examples exist in regard to mobility devices. Missouri states that it will provide three wheeled carts to persons with multiple sclerosis, muscular dystrophy, and arthritis only. North Carolina limits coverage of power wheelchairs to persons who meet four specific criteria. Alabama, Arizona, Florida, Idaho, Missouri, New Hampshire, South Carolina, Texas, Utah and Virginia state they will cover manual but not power wheelchairs at all. Virginia also states that it will provide adult but not pediatric wheelchairs.

All of these limitations violate either or both the "amount, duration and scope" and the "diagnosis based decision making" provisions of the Medicaid program.

* The "medical need" / "utilization control" provision enables states to exercise a "gatekeeping" function over access to Medicaid services. The concepts of "medical need," "prior approval" or "authorization" (the principal means of implementing "utilization controls") and other services limits, require recipients, before a Medicaid service is provided, to submit proof demonstrating that the care or service is in fact necessary to address a medical condition or need, and that it is the least costly appropriate means to achieve the desired result.

* The presence of a "prior approval" requirement is not in and of itself controversial: it is not unreasonable per se for a government benefits program to require participants to apply, and to conduct a review prior to allowing access to program resources. Prior authorization should be only the name given to that procedure; medical need should be only a documentation requirement to gain access to Medicaid services.

i. Medical Need:

* The proper interpretation of "medical need" is one that respects the congressional choices stated in the Medicaid Act. Medical need for assistive technology is established by proof that the requested device or service will address a medical condition and will promote greater independence or self care. Greater independent functioning, greater self determination, greater self care, and greater integration into society are all medical needs for individuals with disabilities. [7]

* When this construction is applied to specific assistive technology devices, medical need for communication devices becomes independent of the identity of the communication partner, and independent of the communication subject. Prosthetics, mobility and positioning devices (e.g., power wheelchairs; orthopedic car seats) become independent of where the person will go and of the purpose for the travel. And, for Medicaid services that are people (e.g., nurses, home health aides, personal care attendants), medical need is independent of the location where their services are provided, (i.e., 'at home' limitations, or 'do for,' but not 'do with' limitations).

* Establishing "medical need" for assistive technology, will require the identification of a diagnosis, type of illness or condition which the technology will address. The medical need will be documented by a statement of the functional limitations imposed

by the identified disability. There also must be a justification or explanation of how the assistive technology will promote the rehabilitation of the identified condition, i.e., how it will change, or create the potential for change in the person's ability to function; how it will improve the person's life. The justification also will explain how the absence of the requested service interferes with the person's ability to act or live independently, or engage in self care.

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[7] This construction of the term "medical need" will permit Medicaid services recipients to consider "next steps," in terms of both residence or program. Medical need will be established if requested assistive technology creates the potential for the person to reduce the level of supervision received, the level of Medicaid services received, or the effects of his or her impairments. Often these "next steps" also will involve a significant decrease in total Medicaid costs. For example, for persons in intermediate care facilities, assistive technology may enable them to move to a lower level of supervised living, which may not even be Medicaid funded. For persons in day treatment programs, assistive technology may enable them to gain the skills required to enter a vocational rehabilitation program or even competitive employment. For persons at home, assistive technology may allow them to be left alone, decreasing the need for home health or personal care services.

* In contrast to how medical need should be interpreted, the present operation of the Medicaid programs in most states is significantly different. Medical need and prior approval are most frequently cited as barriers to every Medicaid service, including those that support assistive technology. They have gained bad reputations, however, largely because they have been misused. Moreover, their misuse has persisted largely because few people know how they should work, and even fewer know how to correct their excesses.

* The most extreme abuse of medical necessity and prior authorization is their use as limits on the statutory concepts of "rehabilitation," "best interests," "amount, duration and scope," and "diagnosis based decision making." If unchallenged and unchanged, this abuse can pose a significant -- even an insurmountable -- barrier to assistive technology funding.

* Medical need will be used as a limit of "rehabilitation" when states impose more restrictive standards than the one stated in the Medicaid Act: "to attain or retain . . . independence or self care. . . ." Probably the most common restriction is that medical need is established only if the service is necessary for the person to receive medical care. The rationale is that Medicaid is a "medical" program, not to be used for "social," "educational," "vocational," or simply "quality of life" or "convenience" goals.

* While these alternate goals are easy to list, they are not easy to define in the context of a particular service or the benefits it will provide. Courts and Congress already have rejected any bright line distinction between a "medical" and "educational" need for services provided to children in schools; and common sense suggests that every service will be intended to improve the recipient's quality of life. [8]

* A second type of restriction will define medical need not only in the context of receiving medical care, but also require proof that adverse medical consequences have arisen or will arise if the service is not provided. This requirement will exist when the state's definition of medical need refers to emergency or "essential" care.

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[8] Also, many services may serve a clear medical care need, and also, serve other goals. This is especially true for assistive technology: a power wheelchair, for example, may allow the user to travel independently to receive medical care, but Medicaid cannot limit the chair's use to that purpose. The user also can go to a museum, or use it for other non-medical purposes. Likewise, an augmentative communication device will allow the user to communicate with a medical care provider, but there can be no restriction of the device so that it can only be used for such communication. That these assistive technology devices have the potential to address more than purely access to medical care needs is no basis to deny them as not medically necessary.

* By focusing on actual or potential harm in the absence of the requested service, this construction of medical need strays very far from rehabilitation, independence or self care, the standards Congress included in the Act. There is no prerequisite of injury or pain prior to receiving any Medicaid service. There is no threshold of suffering.[9]

ii. Least Costly

* In addition to showing that assistive technology is medically necessary, the states can require a recipient to demonstrate that the technology being requested is the least costly that will meet the person's needs. Cost control is a valid "utilization control" under the federal Medicaid criteria. Decisions, or discussions with program administrators will state that Medicaid is not able to provide "luxuries," or "Cadillac services," or "convenience" items.

* Identifying least costly services is a proper task of the assistive technology evaluator. The professional must state whether alternative means, or alternative technology is available to meet the person's needs.

* Care must be taken in identifying alternatives. Alternatives are devices that offer the same opportunities; they are not merely devices that address the same impairment or condition. For example, in augmentative communication, many devices exist, but few have the same characteristics and offer the same degree of communication opportunities. A "Vocaid" will not offer the same opportunities as a "Touchtalker," and therefore, should not be considered an "alternative" to a person whose medical needs can be met by the latter device.

Having stated the general program criteria that may be used to support assistive technology funding, each individual state Medicaid program must be reviewed to identify the specific services under which assistive technology may be funded. In reviewing these definitions, remember that none of them specifically identify assistive technology as available. Instead, the outline provides a means to interpret the definitions to permit assistive technology to be included within the scope of these services.

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[9] The focus on adverse consequences if the service is not provided leads to frequent denials of prior authorization for persons residing in 24 hour care settings. A "Catch 22" is presented: there never will be any unmet medical needs, because the very identification of such needs will result in their being addressed. In addition, because these settings (intermediate care facilities, health related facilities, nursing homes, etc.) have 24 hour professional staff, they are presumed to be able to meet every resident's medical needs.

Neither assumption has any basis in fact. For a person lacking the ability to communicate, staff is unlikely to have the ESP necessary to intuit what the person may need or want. Often, the pressures of other responsibilities force staff to decide the needs and wants of residents who cannot communicate. For residents who lack independent mobility, the same limitation is present. Staff is not available to push residents; instead, staff may decide what resident movement is needed, and when it will occur.

A related issue for persons in facilities is whether the facility should provide the technology as part of its reimbursement rate. Facilities are required to have some types of assistive technology in stock. However, if an individual needs a device for his or her exclusive use, or if the device needs to be modified (often defined as permanently altered) for the person's use, then the technology should be provided by the Medicaid program and not by the facility.

The nine services that are assistive technology funding resources include:

f. "Rehabilitative Services"

* "Rehabilitative services" is an optional service the states may choose to include in their state Medicaid programs (42 U.S.C. Section 1396d(a)(13)).

* The regulations define this service to include:

> any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. (42 C.F.R. Section 440.130(d)).

* This definition is a direct parallel to the definition of "rehabilitation" stated in the Medicaid Act. As stated in the definition, the goal of these services will be to allow recipients to attain or retain the capability for independence and self care.

* As of 1988, 36 states included rehabilitative services in their state plans. When applying for assistive technology as a rehabilitative service, the justification must explain how the technology will provide the functional restoration and improvement that is part of the definition of this service.

g. Preventive Services

* Preventive services is an optional service that the states may include in their Medicaid program (42 U.S.C. Section 1396d(a)(13)).

* The regulations define this service as follows:

> Preventive services means services provided by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law to –
>
> (1) prevent disease, disability, and other health conditions or their progression;
> (2) prolong life; and
> (3) promote physical and mental health and efficiency.
> (42 C.F.R. Section 440.110(c)).

* Assistive technology can serve an important preventive role. It may directly address an existing impairment by preventing its progression, or slowing its pace. It may prevent the onset of new impairments. And, it may prevent, or slow the progress

of "related" impairments.[10]

* As of October 1988, 20 states included preventive services in their state plans.

h. Prosthetic Devices

* Prosthetic devices is an optional service states may include in their Medicaid program (42 U.S.C. Section 1396d(a)(12)).

* The regulations define this service as follows:

> Prosthetic devices means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to --
>
> (1) artificially replace a missing portion of the body;
> (2) prevent or correct physical deformity or malfunction; or
> (3) support a weak or deformed portion of the body (42 C.F.R. Section 440.120(c)).

* Assistive technology devices are most commonly considered prosthetic devices. Minnesota, for example, identifies augmentative communication devices as "prosthetic communication devices." However, the language of the definition does not supply a precise "fit" with the functions served by many assistive technology devices. Assistive technology may "substitute" for a non-working part of the body, and enable the person to overcome the disabling effects of an impairment, but in many cases it will not replace a part that is missing, correct a malfunctioning part, or support a weak or deformed part.

* The definition does supply a valuable "amount, duration & scope" provision: the prostheses should be provided such that they "prevent or correct" the malfunction, i.e., enable the user to be as independent as possible.

* As of October 1988, 47 states included prosthetic devices in their Medicaid programs. However, not all states include coverage for all prosthetic devices. Whether such coverage limits are lawful, is discussed elsewhere. (See footnote 4, above.)

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[10] Examples are easy to identify. A person with impaired lower leg circulation and an inability to propel a manual wheelchair may require a power chair to prevent the onset of gangrene that may result in amputation of the lower legs. A person with full cognitive abilities following a stroke or head injury may require an augmentative communication device to prevent depression or withdrawal from rehabilitation. A person with cerebral palsy may require a power chair and a communication device to prevent self abuse arising from the frustration of the inability to move or to communicate. A person with severe allergies or asthma may require an air filter or purifier to prevent increased severity of symptoms when medications have been shown not to be effective.

i. Durable Medical Equipment

* The Medicaid Act requires that states provide "home health services as part of their Medicaid programs (42 U.S.C. Section 1396d(a)(7)). The federal law simply identifies this service, without any further explanation of its purpose or scope.

* The federal regulations define home health care services to include durable medical equipment:

> Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) of this section are required services. . . .
>
> (1) nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency . . . .;
> (2) home health aide service provided by a home health agency;
> (3) medical supplies and equipment, and appliances suitable for use in the home; (42 C.F.R. Section 440.70(b)).

* Home care services as well as durable medical equipment are a self evident source of assistive technology coverage. Human services, such as nurses, home health aides and personal care attendants, may make it possible for technology dependent children to be cared for at home as compared to residing in an intermediate care facility or hospital. Other services provided at home may include physical, occupational, and speech-language therapy; thus, assistive technology related to mobility, positioning, and communication will be available as home care supplies and equipment, or as the supplies and equipment associated with those services (see discussion below).

* The Council on Scientific Affairs of the American Medical Association (AMA) recently issued a report on "Home Care in the 1990s" which fully supports the provision of assistive technology as adjunct to home care services under the Medicaid program (*Journal of the American Medical Association*, 263, 9, pp. 1241-1244). The rehabilitation goal which is stated here to be a valid goal of Medicaid provided home care is acknowledged by the AMA to be an inherent part of home care in general:

> Home care can be defined as the provision of equipment and services to the patient in the home for the purpose of restoring and maintaining his maximal level of comfort, function, and health.
>
> The goal for rehabilitation therapy is not merely independence at home, but reintroduction into the socioeconomic life of the community (263 J.A.M.A. at 1242, 1243).

Council Report

Home Care in the 1990s

Council on Scientific Affairs

Home care is a rapidly growing field that is beginning to attract greater physician interest and participation. Cost-containment pressures have led to reduced institutionalization in hospitals and nursing homes and to more patients, both acutely and chronically ill, being cared for in their own homes. Undergraduate and graduate medical education programs are developing home care curricula, and academic medicine is beginning to develop a research agenda, particularly in the area of clinical outcome measurements. Medical care in the home is highly diversified and innovative. The areas of preventive, diagnostic, therapeutic, rehabilitative, and long-term maintenance care are all well represented as physicians develop new practice patterns in home care.

(JAMA. 1990;263:1241-1244)

HOME care is currently one of the most rapidly growing areas of the health care system. While hospital beds and utilization have declined and nursing-home beds have increased by 2% annually, the home health industry growth rate has been 20% per year for the last 5 years.[1]

Traditional physician house calls had been decreasing steadily since the 1940s, and many physicians saw themselves as peripheral to the new home care field, unfamiliar with the jargon, techniques, and equipment[2] and uncomfortable when asked to sign certifications of the need for home care services. This situation began to change with the cost-containment pressures of the 1980s as more acutely ill patients were cared for at home under much closer physician supervision than in the past. Surprisingly, recent surveys of primary care physicians (from the fields of family practice, general medicine, and internal medicine) have shown that 53% to 82% of them make house calls.[3]

The growing demand for greater physician involvement in home care is reflected in the recommendations for including specific home care training in accredited family practice and internal medicine residencies. Home care clinical and administrative experiences are a requirement in the new geriatric fellowship programs. Undergraduate medical school programs are beginning to add home care rotations.

DEFINITION

Home care can be defined as the provision of equipment and services to the patient in the home for the purpose of restoring and maintaining his or her maximal level of comfort, function, and health.

Equipment that has been adapted especially for home care ranges from blood glucose monitoring for the diabetic through computerized total environments for the disabled and mini-intensive care units with ventilators, central venous lines, and long-distance telemetry for the acutely ill. There is an ever-growing range of assistive devices to help the patient overcome impairments in speech, vision, hearing, mobility, and cognition. Finally, there are devices to improve communication, socialization, and recreation for the homebound, from specialized telephones and computers to talking books and captioned television.

The myriad services that may be necessary in the home are provided by physicians; nurse specialists; registered and licensed practical nurses; physical, occupational, and speech therapists; medical social workers; nutritionists; respiratory therapists; laboratory technicians; vocational and educational rehabilitation personnel; podiatrists; pharmacists; dentists; psychologists; audiologists; optometrists; home health aides; personal care assistants; homemakers; chore housekeepers; volunteers delivering "meals-on-wheels," friendly visitors; and home construction workers for the building of ramps and other structural changes. The primary care giver, however, is usually a member of the family.

Medical care at home can be preventive, diagnostic, therapeutic, rehabilitative, or long-term maintenance care. Each area has many historical models as well as modern innovations.

PREVENTIVE CARE AT HOME

Many primary care physicians see preventive home care as an extension of their office practice. Thus, the home care program for an ambulatory patient with osteoporosis would be planned

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This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all of the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. This report reflects the views of scientific literature as of June 1989.

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with the goal of preventing falls and fractures and could include home safety equipment such as transfer benches and grab bars; patient education and counseling on safe environments, including adequate lighting, stair rails, and the removal of scatter rugs; joint protection instruction and assistive equipment for daily activities; and a physical therapy program to improve gait and balance.

Preventive care is also a part of the treatment plan of an acute episode of illness, directed at preventing further complications and restoring the patient to the level of function prior to the acute illness. Thus, the home care program for a patient following an acute myocardial infarction might include daily monitoring to anticipate and hopefully prevent or ameliorate the development of cardiac arrhythmias, recurrent infarction, hypotension, congestive heart failure, and the many other possible complications of an unstable cardiovascular system. Continuous evaluation of the drug therapy program includes in-home testing for blood levels of the different drugs and electrocardiograms or rhythm strips (frequently transmitted via telephone lines) as well as careful elicitation of the patient's symptomatic reactions to the treatment. Because the burden of care falls on the patient and family, attention to family dynamics, the need for behavioral modification, and patient education and counseling to enable compliance with the medical plan of treatment is an essential part of preventive home care. After stabilization, cardiac rehabilitation, including physical therapy, helps determine the maximal level of functioning, the prevention of invalidism, and the maintenance of health and well-being.

DIAGNOSTIC CARE AT HOME

Although most physician interactions with their patients have a diagnostic component, under current cost-containment pressures the traditional diagnostic workup has been pushed out of acute-care hospitals into outpatient settings, physicians' offices, and the home.[6] Although the outpatient setting may be an improvement on the hospital setting for diagnostic examinations for the majority of patients, for the frail elderly and chronically ill the outpatient process can be physically, emotionally, and financially difficult. Patient stress may obscure accurate diagnoses under these conditions.

It is not surprising that home visit assessments following assessments in a physician's office revealed an average of two new problems per patient and a range of one to eight new recommendations for the medical treatment plan of care in a recent study by Ramsdell et al.[8] Twenty-three percent of the newly found problems could have resulted in death or significant morbidity. Thirty percent of the new problems, identified only at home, were medically related, 38% were psychobehavioral, and 36% involved serious safety hazards.

As more medical school, residency, and fellowship programs are developing home care educational curricula, the reports and evaluations of these home care rotations emphasize the improvement in diagnostic skill and sensitivity.[illegible]

The diagnostic value of home visits was recognized in the 1988 National Institutes of Health Consensus Development Conference Statement on "Geriatric Assessment Methods for Clinical Decision-making,"[illegible] which stressed the importance of home visits to evaluate functional status and environmental characteristics—two of the five major diagnostic areas of a comprehensive geriatric assessment.

Koenig[7] has selected some useful indicators for diagnostic visits in the home:

1. Sick patients with multiple medical problems and mobility difficulties who are taking multiple medications; any patient with recurrent falls.
2. Patients with multiple chronic illnesses and suspected interacting psychosocial problems.
3. Sick patients who are responding poorly to medical therapy.
4. Chronically ill patients who are difficult to relate to and seem unsatisfied with their care.
5. Terminally ill patients who wish to die at home.
6. Homebound disabled patients whose caretakers are fed up, frustrated, or reaching their tolerance limits.
7. Suspected cases of patient abuse.
8. Older persons with known significant medical problems who refuse to be seen in the office.
9. Recently bereaved homebound persons with coping difficulties.

Physicians who see many patients at home begin to practice a different style of diagnosis than that traditionally taught and practiced in hospital settings. Portnow[11] and Bernstein[7] describe this as "stepwise" diagnosis as opposed to the pressurized search for the "definitive" diagnosis.

Hospital protocols and standards of care attempt to arrive at conclusive diagnoses within the shortest period of time, subjecting the patient to the full battery of possible tests almost simultaneously. Some of the tests may not be necessary if the physician can tolerate the uncertainty and follow a modified plan of serial evaluative tests and a trial of treatment that is, in itself, diagnostic. This stepwise diagnostic approach is characteristic of good medical practice in an ambulatory setting; in the home care setting, with the support of home nursing staff, it can be applied to seriously ill patients who were previously seen only in the hospital.

A measured pace of diagnosis and trial of treatment is particularly appropriate for the elderly patient, whose response to treatment is often slow. This approach, geared to patient comfort as well as safety, may avoid overreaction and overtreatment.

Sophisticated medical diagnosis at home can be provided through the physician mobile medical van services being developed around the country.[8] A computerized emergency room in a van[8] has the capacity to convert x-ray film to digitized audiovisual signals that are transmitted via modem to the referring physician's office within 30 minutes from the time the "mobile" physician arrives at the patient's home. Full laboratory, pharmacy, and therapeutic services such as casts and traction can be available more rapidly through this van than through the usual ambulance/emergency room route.

From the patient's point of view, home care has always seemed the most efficient, effective, and least traumatic form of medical care. The perceived inefficiencies of home diagnosis from the physician's point of view are being balanced by more complete diagnoses, more appropriate diagnosis/treatment plans, easy availability of home laboratory services, and the full range of multidisciplinary support services offered by home health agencies.

THERAPEUTIC CARE AT HOME

Virtually every treatment modality in the hospital that can be made portable can be provided in the home. Some patients now are discharged directly from intensive care unit to home, trailing behind them portable pumps, central venous lines, ventilators, and so forth. One of the most rapidly growing areas in medical technology is the design and production of equipment specifically for use in the home. The equipment used in the hospital for intravenous (IV) therapy (IV poles, piggybacked glass bottles, pumps, steel needles, arm boards, and restraints) all seem old-fashioned when compared with the streamlined, simplified, tamperproof home IV products that make it possible for solutions in lightweight plastic containers to be tucked into pockets while delivering consistent dosages not dependent on gravity or the manual dexterity of the patient. Patients receiving IV therapy

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at home are not immobilized as they are in the hospital. Indeed, many return to work while receiving therapy. Tiny computerized pumps allow cancer patients to safely control their own dosage of continuous IV or subcutaneous narcotics. Babies who use ventilators crawl around their own living rooms; older children tuck their portable ventilators under the wheelchair when they go to school.

Programs have been developed not only to deliver needed home medical supplies, but also to handle the collection and safe disposal of used, infectious, or hazardous materials.[illegible]

Hospital treatments from débridement of decubiti to prosthetic training to bed baths can be provided in the home under the direction and supervision of the patient's physician. However, the physician, who can monitor hospital care on-site daily, has much more difficulty monitoring home care over the telephone and through the mail.[illegible] Home visits by the primary physician may be medically necessary and appropriate for patients with unstable medical conditions or technologically complex care.

As with technological equipment, the provision of professional therapeutic services in the home is being streamlined and individualized in ways not yet possible in the less flexible hospital setting. For the appropriate patient, nursing services may be provided one-on-one for 24 hours a day (for example, for the complicated care of a ventilator patient) down to half an hour per month (to change a Foley catheter). Whereas nurses in the hospital make rounds three times a day on all patients, the home care rounds are individualized from daily visits for dressing changes or other treatments to three times a week or once a week, depending on patient and family need. The determining factor in the frequency of visits is not only the patient's condition but also the ability of the patient and family to learn how to provide the needed care themselves. The goal of home care is to make the patient and family self-sufficient.

The involvement of patients and families in the treatment programs is one of the factors that lead to the enhancement of therapeutic effectiveness that is a hallmark of home care.

Rossman,[illegible] in citing instances of unexpected improvement in home care patients, credits the "positive and ameliorative psychologic factors" in the home setting. Increased motivation and patient control and decreased anxiety and depression can "alter an illness trajectory." A careful study of home vs hospital care for stroke patients showed that the home program resulted in a quicker return of function and a reduction of mortality.[illegible] Other studies have demonstrated improved clinical outcomes following home care.[illegible]

One area in which the enhancement of medical care in the home can be seen most clearly is in hospice care. The goals of hospice programs, with their emphasis on palliative care, on patient comfort and patient choice, on emotional and spiritual as well as medical support, and on death with dignity, are extremely difficult to integrate into the philosophy and methodology of modern hospitals. The home is definitely the superior therapeutic environment for the majority of hospice patients.

REHABILITATIVE CARE AT HOME

A broad range of rehabilitation services in the home can be streamlined and individualized based on the patient's condition and the abilities of the patient and family to participate in and supplement care.[illegible] There is at least one program that provides intensive rehabilitation in the home (avoiding any need for a stay in a rehabilitation hospital) by sending physicians, rehabilitation nurses, and physical, occupational, and speech therapists into the home on a daily basis.[illegible] Most home rehabilitative care follows hospitalization. Many patients appear to progress as rapidly at home receiving only 3 hours of physical therapy a week as they did in the rehabilitation hospital with daily or twice-daily therapy. This goal can be achieved by the use of carefully graduated home programs when the patient and family are motivated to follow through with the therapeutic exercises. The barriers on streamlining the therapy program are the complexity of the program and the educational and psychological limitations of the patient and family. There are many studies that stress the importance of the family and social support network in the functional recovery of elderly patients.[illegible]

The goal for rehabilitation therapy is not merely independence at home, but reintroductions into the socioeconomic life of the community.

The interdisciplinary team planning for the disabled child works toward the goal of the child's entrance into a school program, into extracurricular activities, and eventually, at adulthood, into a job and normal productive life.

Vocational rehabilitation is an important part of home rehabilitation programs and serves as a liaison to community-based job training and job placement programs. One new group of home care patients for whom adaptive work strategies and retraining programs are particularly important are patients with AIDS.[illegible]

The rehabilitation program for the elderly patient often gets diminished by "ageism" into the acceptance of minimal independence in the home as sufficient, rather than the traditional goal of maximum functional capability. There is no reason not to offer the elderly patient a full therapeutic program that stresses community ambulation and mobility (including driving a car). The physiological and psychological benefits of mobility and socialization more than offset the additional cost.

LONG-TERM MAINTENANCE CARE AT HOME

Chronically ill and disabled patients have a continuing need for medical and supportive care to maintain their maximum functional level of activity. In addition to the monitoring/diagnostic services of the physician, supportive care services are needed; these are provided by a variety of people from family members and friends to home health aides, homemakers, housekeepers, etc. Many patients also need monitoring, reinforcing, and educational upgrade visits from therapists and nurses.

Physicians who maintain only office-based practices, requiring the patient to get out of the house to see them, often augment their practice by the use of home health nurses to monitor the patient between office visits. Increasingly, physicians are choosing to make home visits to selected patients whose mobility is seriously impaired.[illegible]

Consistent medical management may stabilize or prevent the progression of various chronic conditions, but the patient remains frail and impaired and unable to independently manage the various activities of daily living. Approximately 85% of the patients who need long-term supportive care receive it from their families and friends. Only 15% receive formal paid services from any of the various community resources.[1] The financial, physical, and emotional burdens on the care givers can be very great,[illegible] and there is need to develop programs to strengthen the informal support system through provision of respite care, counseling, service credits, and possibly tax incentives.

The explosive growth of the elderly population that we are currently witnessing, with those over 85 being the most rapidly expanding group, leads to predictions that long-term maintenance home care will be the largest area in the home care field. Although 20% of those over 65 can be considered "frail" elderly who experience functional limitations secondary to chronic disease processes,

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46% of those over 85 who live in the community fall into the frail elderly grouping and are therefore candidates for long-term maintenance home care.[27]

Children and adults who are disabled (whether from congenital problems, neuromuscular disease, or posttraumatic injuries) may require supportive care assistance as well as intermittent nursing and physical therapy services to ensure maintenance of their maximum functional capabilities.

The need for assistance with activities of daily living such as eating, dressing, bathing, toileting, transferring, and walking is often thought of as a "social" need, not a "medical" one. Yet, the provision of these services, either by family members or a paid community worker, is crucial to the health and well-being of the patient.

The first attempts at studying community-based long-term care have led to contradictory findings as to nursing-home or hospital use or total costs,[28] although most studies stressed the "quality of life" improvement and satisfaction reported by the patients. Studies by Hughes et al[29] on a carefully selected "target" population of frail elderly show that provision of long-term care at home significantly lowers the risk of permanent admission to sheltered or intermediate-level nursing homes (but not to skilled nursing homes). There was no difference in mortality rates between the comparison group of frail elderly who received meals-on-wheels and traditional medical intervention and the study group who received the long-term home care program over the 4-year evaluation period. However, there was a surprise finding of improved cognitive functioning in the home care group after 9 months, which was continued through the 48 months of the study.[30] The study concluded that the home care program (which consisted primarily of visits by home health aides with occasional visits by social workers, nurses, and physical and occupational therapists), when seen as a "treatment," had a "beneficial effect on cognitive status." The group receiving home care services also showed a greater amount of social contact with friends and better physical and mental health assessment scores. This study documents the "enhancement of care" that is so often referred to as the major benefit of home care.

Provision of supportive care can thus be seen as "enhancing" the therapeutic program, but is it medically necessary for the success of the medical treatment plan of care? One of the few studies addressing this issue was conducted by the Wilder Foundation[31] when they followed a group of frail elderly patients who had been receiving home health aide services through the Alternative Care Grants program in Minnesota. This was a state program, funded through Medicaid "waivers," that identified patients "at risk" of nursing-home placement via preadmission screening and then provided home care as an alternative. In 1986 a shortfall of available funds forced Ramsey County to decrease its alternative care service, which was accomplished by tightening financial eligibility requirements. Two hundred eighty-one clients were dropped while 178 were maintained in the home care program. All 459 clients were followed in the study. After 8 months, the group that no longer received home care services had twice as high hospitalization and mortality rates as those who continued to receive the home care program. This study highlights the medical necessity of supportive care.

CONCLUSION

Home care is an increasingly important aspect of medical practice. In the continuum of health care settings, little attention has been paid to the physician's role in this multifaceted arena. Practicing physicians in many specialty areas currently interact with a wide variety of home care providers; most of them spend from 5% to 10% of their time, but some spend up to 100% of their time, in home care.

More clinically oriented research is needed on patient care in the home before we can know with any assurance what interventions are most effective and appropriate. Until now, most of the research done has concentrated on cost rather than clinical practice and outcome. As academic medicine becomes more involved with home care, we can expect to see the research emphasis shift into the needed clinical areas. As practicing physicians become more involved with home care, we can expect to see even greater innovation and growth in this new/old field of medical practice.

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j. Occupational Therapy; Physical Therapy; Speech-Language Therapy

- The Medicaid Act lists these services as optional which states may include in their Medicaid programs (42 U.S.C. Section d(a)(11)). The Act lists, but does not define these services.

- The federal regulations define these services as follows:

> **Occupational therapy** means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment (42 C.F.R. Section 440.110(b)(1)).
>
> **Physical therapy** means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment (42 C.F.R. Section 440.110(a)(1)).
>
> Services for individuals with speech, hearing and language disorders means diagnostic, screening, preventive and corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. It includes any necessary supplies and equipment (42 C.F.R. Section 440.110(c)(1)).

- The ability of these services to support assistive technology funding is tied to the inclusion of "necessary supplies and equipment" in each definition.[11]

- The limitations that states have attempted to impose on the scope of these services, and the likely illegality of those limits, already has been discussed.

k. Early, Periodic Screening, Diagnosis & Treatment

- The Medicaid Act states that this service, known as "EPSDT," is required to be a part of each state's Medicaid program. 42 U.S.C. Section 1396d(a)(4)(B).

- EPSDT is not a "service" per se, but a provision enabling children below the age of 21 to receive services from the state's Medicaid program. 42 C.F.R. Sections 441.50 - 441.62. The key to EPSDT coverage is what services these children will be entitled to receive.

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[11] An augmentative communication device will be necessary to provide speech, language therapy to a person who lacks or has lost the ability to communicate by verbal or manual means. Orienting the person to the device is a valid use of speech, language therapy services. Likewise, a similar analysis can be applied to mobility devices and other types of technology.

- EPSDT requires states to provide a screening that includes a health and developmental history, a comprehensive physical exam, vision and hearing testing, laboratory tests, and dental screening for children over 3 years of age. States must establish "periodicity schedules" that set out the frequency of screening and provide corrective treatment for problems identified during screening (42 C.F.R. Section 441.50 *et seq*).

- As of April 1, 1990, far more specificity is required to be part of the EPSDT program. Individual periodicity schedules are now required for general health screenings, and vision, dental, and hearing services. The intervals must meet "reasonable standards of medical and dental practice (42 U.S.C. Sections 1396d(a)(4); 1396d(r)).

- In addition, and of greatest importance to states that have minimal Medicaid programs, or which have attempted to limit provision of assistive technology, the Omnibus Budget Reconciliation Act ("OBRA 89") mandates that as of April 1990, states must provide all "treatment" for which federal reimbursement is available, "whether or not such services are covered under the State plan" (42 U.S.C. Section 1396d(r)(5)). Thus, no matter what the state may cite as coverage limits, none can be imposed on Medicaid eligible persons below age 21.

- The significance of the OBRA 89 provision is enormous. In short, persons less than 21 years of age have available to them all the assistive technology that Medicaid will cover under any service. In addition, some children will be eligible for services independent of their status as participants in a state Medicaid waiver.

l. Intermediate Care Facility Services

- The Medicaid Act lists intermediate care facility services as an optional service that states may include in their Medicaid programs (42 U.S.C. Section 1396d(a)(14)). The federal law also defines intermediate care facilities, and intermediate care facility services (42 U.S.C. Sections 1396d(c); 1396d(d)).

- The key element of ICF services is the concept of "active treatment."[12]

- The federal regulations set forth the services and equipment that comprise "active treatment" and must be made available to residents of intermediate care facilities (42 C.F.R. Part 483). Like EPSDT, there are no unique services that are listed under the ICF services definitions; rather, they are a vehicle for securing health, nursing, rehabilitative, social, physician and other services, as defined in the general Medicaid program, and as appropriate, assistive technology (42 C.F.R. Section 483).

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[12] Active treatment is defined as "aggressive, consistent implementation of a program of generic training, treatment, health services, and related services". Included in an individual program plan must be "relevant interventions to support the individual toward independence."

Assistive technology services and devices covered could include:

- mechanical supports if needed to achieve proper body position, balance, or alignment..
- moving about outside the bedroom area..
- speech and language development to communicate basic needs..and;
- independent living skills necessary for the client to be able to function in the community.

* As of October 1988, every state except Arizona included ICF facility services as part of its Medicaid program.

SECTION II

OUTLINE OF SPECIAL EDUCATION LAWS & RULES

* The Education for All Handicapped Children Act, enacted in 1975, and substantially amended in 1986, is most commonly known as the EHA or as Public Law 94-142, 20 U.S.C. Section 1400-1485.

* The EHA creates three programs, each addressing a different age group of children with handicaps. The largest program addresses the special education and related services needs of children with handicaps who are between age 5 and 21. The second addresses pre-schoolers, children aged 3 and 4. The third program is directed to "early intervention" services that may be needed by infants and toddlers with handicaps. Part A of the outline describes the programs for pre-schoolers and children 5-21 together. Part B describes the early intervention program.

Part A. Special Education Programs For Children Age 3 - 21

I. Introduction

* The EHA programs for children age 3 - 21 are based on congressional findings that more than one half of all children with handicaps in the nation were not receiving appropriate educational services. Of this total, more than a million children were excluded entirely from the educational system, and countless others were in regular education programs where they could not be successful, or were locked into totally segregated, and often educationally meaningless "special" classes. Congress also recognized that schools frequently were not providing the support services these children needed. This forced parents to seek the services from other sources, and at their own expense, or forced the children to go unserved.

* In total, these EHA programs are estimated to address the needs of more than 8 million children with disabilities, including those who require assistive technology devices and services.

* The EHA has as its root the principle of "equal protection" stated thirty-six years ago, in *Brown v. Board of Education*. In *Brown*, the Supreme Court described public school education as "perhaps the most important function of state and local governments." It supplies the foundation onto which children will build productive lives. This statement was made to support racial integration of the schools; through the EHA, it is equally applicable to children with handicaps.

* The EHA supplies children with handicaps the same promise of integration as *Brown* offered to children of color. The EHA's promise to children with handicaps is that they no longer will be entirely excluded from school or its activities, or unnecessarily segregated from other children. The EHA requires that children with handicaps be

integrated physically, academically, socially and societally, with other children in their local school districts.

* Just as *Brown* required the physical integration of children into the same buildings and classrooms, the EHA concept of physical integration includes educating children with handicaps in school buildings where "regular" educational activities are conducted, rather than segregated settings.

* The EHA further requires that physical integration be matched by academic integration. Children with handicaps must be educated with other children in regular classes, and they can be removed from those classes and placed in self contained settings only if supplemental aids and services have not been successful in allowing the child to continue learning in the regular class. And, even if children are placed in a separate class, to the maximum extent appropriate, they must be educated in "mainstream" or "regular" classrooms with children who have no handicaps.

* Third, the EHA requires schools to ensure opportunities for social integration of children with handicaps, to make all school facilities and activities available to them, and to the maximum extent possible, to have the facilities and activities be shared with children who are not handicapped. Lunch, art, music, gym, assemblies, field trips, clubs and after school activities must be integrated and available to all students, and a handicapped child can be excluded from participation in these activities only if the school can demonstrate he/she could not benefit from the social interaction they offer.

* Fourth, the EHA requires that the educational programs offered to children with handicaps lay the foundation for these children to be integrated into the society beyond school. School must be seen as part of an ongoing service system, not a unique environment which ends when the child drops out, graduates, or "ages out." Schools must provide training for work; training for independent living; training for access to community services, based on each child's unique abilities. The EHA requires educators to throw out the stereotypes about the abilities and futures of children with handicaps and to devise and implement new programs that will enable them to be as productive and/or independent as possible.

* Finally, through the early intervention program for infants and toddlers with handicaps, the EHA requires educational and health systems to become involved with children at the earliest possible time. Early intervention and pre-school programs must be used to eliminate potential handicapping conditions, or to lessen their effects prior to the child's arrival at school.

* The EHA refuses to accept the schools as they were before the Act was passed; equally true, the EHA does not accept that handicapping conditions are "fixed" and not amenable to preventive services. Rather, the operating principle of the EHA is that schools can and must change to provide "appropriate" educational services, so that there will be the greatest possible changes in children with handicaps.

- In addition to the EHA, children with handicaps also have rights pursuant to the Rehabilitation Act of 1973. Section 504 of the Rehabilitation Act, 29 U.S.C. Section 794, imposes a duty of "non-discrimination" on all recipients of federal financial assistance. States and local school districts receive many different sources of federal financial assistance, including EHA funds, making them subject to the provisions of Section 504. The interrelation between the EHA and Section 504 also is discussed in Part C below.

- The "integration" requirements of the EHA and Section 504 force two types of changes in existing educational programs and services: when the programs are deficient, they must be improved; and when new needs are identified, new programs must be created.

- One limitation, however, is that neither the EHA nor Section 504 provide many specific requirements for the improved or new programs. This is an important potential barrier to the introduction and assimilation of assistive technology into the schools. The Act merely states congressional "goals" for individualized and "appropriate" programs, and "least restrictive environment." It leaves extraordinary discretion to states and local school officials in regard to their implementation. The EHA recognizes that historically, responsibility for development and implementation of educational programs has been at the local school district and state education department levels. Congress has not been intimately involved in these education matters, and the EHA does not change that historic division of responsibilities.

- Nonetheless, the EHA and Section 504 already have and can continue to promote extraordinary changes in school programs, including the introduction of assistive technology. The EHA and Section 504 create substantive rights to specific types of programs and services. They also create procedural safeguards to ensure the programs and services are developed and implemented properly and in a timely manner.

- The EHA is a straightforward law to read and understand. It describes its programs in very few words, and it is accompanied by clearly written and fairly comprehensive regulations (34 C.F.R. Part 300 (special education for 5-21); Part 301 (pre-school programs); Part 303 (early intervention)). In addition, the implementation of the EHA has been largely a matter of public record at both the federal and state level.[13]

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[13] There are two principal resources for EHA information. These resources are required reading in an effort to gain a solid understanding of the EHA, and to remain current in this very quickly changing field. They also are essential if Tech Act staff hope to achieve reforms of current practices, such as integrating assistive technology into education programs.

The most comprehensive resource is the *Education for the Handicapped Law Reporter* ("EHLR"), a multi-volume reporter published every two weeks. The EHLR is published by the LRP Publishing Company. It contains a complete copy of all the applicable federal laws and rules. It reports interpretive and enforcement materials issued by three U.S. Dept of Education offices that administer and oversee the EHA: Office of Civil Rights ("OCR"); the Office of Special Education Programs (OSEP); and the Office of the Assistant Secretary for Special Education & Rehabilitation Services (OSERS). The EHLR also provides the full text of selected state level administrative decisions, and many federal court opinions.

The second resource is a compilation of all final state administrative decisions involving special education. The state government (or a private publisher), may publish all final administrative decisions issued by the state Commissioner of Education in regard to EHA (and other) issues. If published, these decisions

BEST COPY AVAILABLE

* Although the law and rules are clearly written, there are many potential traps at both the decision making level for an individual child and at the policy development level for states and local school districts. Two contributing factors are that special education decision making involves a lot of people at every decision making step. These characteristics create enormous challenges to "outsiders," such as state Tech Act staff, who seek to advance the importance of assistive technology to state education department or local school district officials.

* Whether attempting to shape policy at the state or school district level, or when discussing the benefits of assistive technology for a particular child, Tech Act staff must be able to demonstrate familiarity with the rules and procedures applicable to special education programs. Without a demonstration of both assistive technology and special education expertise, Tech Act staff most likely will have their recommendations summarily dismissed at every level of the special education decision and policy making process.

II. STATE PLAN REQUIREMENTS

* The EHA, like Medicaid, operates through "cooperative federalism." States that agree to implement the EHA's requirements are eligible for federal financial assistance. To receive federal funding, states must provide assurances in a state plan that all children with handicaps in the state will receive special education and/or early intervention programs and services consistent with the EHA's requirements.

A. Special Education & Related Services for Children with Handicaps Age 5-21

* States must choose to participate in the EHA. They do so by submitting an annual state special education plan to the Office of Special Education Programs in the U.S. Department of Education. The annual state plan contents are set forth in the EHA (20 U.S.C. Sections 1412 - 1414; 34 C.F.R. Sections 300.110-.153; .220-.240).

* The annual plans must provide assurances that the participating states will provide all the substantive and procedural rights stated in the EHA. They must assure that all handicapped children between age 5 and 21 will be provided a "full educational opportunity," as well as a "free appropriate public education ("FAPE")" (Section 1412(2)(A);(B)). The full educational opportunity requirement means that handicapped children must be allowed to participate and to benefit from all programs and services -- academic, non-academic, and extra-curricular -- that are available to non-handicapped children (34 C.F.R. Section 300.304-.307). The FAPE, described in Section III, is the substantive right at the core of the EHA.

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will be available by subscription, and also are likely to be found in the government or legal documents sections of university and/or public libraries. Titles of these decisions may be "Opinions of the Commissioner of Education" or "Education Department Reports." Unfortunately, this compilation may not be available in all states.

* To accomplish these goals, states must describe a comprehensive "child find" system, in which all handicapped children in the state are identified, located, and evaluated. (Section 1412(2)(C); 34 C.F.R. Section 300.300(Comment)).

* States also must assure that once evaluated, handicapped children will be provided a FAPE consistent with an individualized education program ("IEP"), and that the placement for that program be in the "least restrictive environment" appropriate to the individual child's handicapping condition (Section 1412(4)-(5)).

* States must assure that all the EHA's procedural safeguards will be provided to all handicapped children (Section 1412(5)(B)).

* Finally, states must assure that there are procedures that will promote the development of sufficient numbers and types of trained staff and appropriate facilities to meet the needs of all handicapped children in the state (Section 1413).

* Although states must submit these plans, local school districts are primarily responsible for the implementation of the EHA. All the foregoing requirements also apply at the school district level. A separate plan is required to be submitted by school districts to the state education agency as a condition of EHA funding being passed on to the local level (Section 1412(4); 1414).

B. Special Education & Related Services To Pre-Schoolers Age 3 and 4

* To be eligible for pre-school funding, states must submit a plan that extends to 3 and 4 year olds the same rights, programs and services that are applicable to children 5 - 21 years old (34 C.F.R. Section 301.10 -.11).

* The pre-school program allowed states to initiate its program in two steps: first, to receive EHA funding in fiscal years 1988, 1989, and 1990, states had to assure that special education and related services would be available to children age 3-4. By FY 91, all children age 3-4 must be assured a complete free appropriate public education ("FAPE") as is available to children age 5-21 (34 C.F.R. Section 301.10).

III. INDIVIDUAL ELIGIBILITY CRITERIA

* The individual eligibility criteria for the EHA programs for children age 3-21 are quite simple. The EHA seeks to open the doors to an appropriate education to all handicapped children: the full name of the EHA is the Education for All Handicapped Children Act.

* In addition, one of the central concepts of the EHA is an entitlement to a Free Appropriate Public Education; there are no financial eligibility criteria. Handicapped children with a wide range of impairments, and from both rich and poor families may participate in and benefit from EHA programs and services.

- Subpart B of the EHA, ("EHA-B") describes the program for children age 3 to 21. This program has only two eligibility criteria: that the child be between age 3 and 21, and that the child be "classified" as handicapped.

- Once classified, the child will be eligible for all the substantive and procedural rights stated in the EHA.

A. Handicapped Children

- The definition of handicapped children has two parts: first, a child must be evaluated and found to have a specified impairment. Second, because of the impairment, the child must need special education and related services.

The EHA lists 9 impairments:

- mental retardation;
- hard of hearing;
- deaf;
- speech or language impaired;
- visually handicapped;
- seriously emotionally disturbed;
- orthopedically impaired;
- other health impaired;
- specific learning disabilities; (20 U.S.C. Section 1401(a)(1)).

The EHA regulations include two additional impairments:

- deaf-blind
- multi-handicapped

The EHA regulations also state definitions of all 11 listed impairments (34 C.F.R. Section 300.5).

- An important limitation of the EHA is that it does not have any "catch-all" definition to permit children with conditions not specifically listed in the law or rules to be classified. [14]

- If a child has one of the listed conditions, the second classification criterion also must be satisfied. It requires the child to demonstrate that because of the condition, s/he requires special education and related services. The EHA regulations expressly state that a child who may have a listed condition, but who does not require special education, will not be classified as a handicapped child under the EHA (34 C.F.R. Section 300.14(comment)). [15]

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[14] This is a major flaw and a major irony: the principal purpose of the EHA is to require the development of individualized programs suited to each child's unique needs. The EHA expressly forbids children to be excluded from receiving an education because of the nature or severity of his/her handicap; also, the EHA forbids program and placement decisions to be based solely on the child's handicap. Yet in the first step to determine who is covered by the EHA, specific categorization is required.

Even 15 years after the EHA was first enacted, and despite the recognition that some children are being wrongfully excluded from EHA programs and services, or are having an extremely difficult time establishing their eligibility, the congressional response in a current reauthorization of the EHA is simply to propose adding more conditions to the categorical list. Pending are amendments that would add autism, traumatic brain injury, and attention deficit disorder to the list of EHA handicapping conditions. (Most recently, the Education Department stated that ADD or ADHD fits under the existing definition of learning disability. 16 EHLR 961 (OSERS 1990))

- A child who has an EHA listed condition but who does not require special education, or one who has a condition not on the EHA list, may still be entitled to the services s/he requires through the provisions of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794. The rights and protections afforded by Section 504 are discussed below.

- Once a child between age 3 and 21 establishes that s/he is handicapped, there are no other eligibility criteria. Family income and resources are expressly not an eligibility criterion. Public school education is available to all children residing in a school district, rich and poor alike. The EHA ensures that children with handicaps also have that right.

IV. PROGRAMS & SERVICES

- The EHA does not state precisely what educational program must, or even what can be provided to handicapped children. Elementary and secondary education always has been administered by local and state authorities, with a minimal federal role. Also, because the EHA requires individualized planning for each handicapped child, the resulting variety of programs and services defies simple definition. For this reason, the EHA lists only general goals as to its "integration" expectations.

A. "Free Appropriate Public Education"

- Once "classified" as handicapped, a child is entitled to receive a "free appropriate public education" or "FAPE."[16] A FAPE is mandatory for each child with handicaps.

- Both the EHA and regulations state that a FAPE consists of special education and related services that

  A) have been provided at public expense, under public supervision and without charge;
  B) meet the standards of the State education agency;
  C) include an appropriate pre-school, elementary, or secondary school

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[15] The comment states:

> (1) The definition of "special education" is a particularly important one under these regulations, since a child is not handicapped unless he or she needs special education...

[16] A Free Appropriate Public Education is abbreviated here as FAPE for convenience. In correspondence and conversation, this phrase is shorted to "appropriate education." It never is referred to as FAPE (sounds like "tape").

education in the State involved; and

D) are provided in conformity with the child's individualized education program (20 U.S.C. Section 1401(18); 34 C.F.R. Section 300.4).

* In addition, each child's FAPE must be provided in the "least restrictive" educational setting, and be implemented by appropriately trained and qualified staff (34 C.F.R. Sections 300.380 -.387; 300.550 - .555).

* FAPE is the general term given to all EHA requirements owed to handicapped children. Through its various component parts (free education, special education, appropriate education, related services, least restrictive environment) children can receive assistive technology as well as all other programs and services that will enable them to benefit from the EHA's physical, academic and social integration goals.

* Each of the significant terms within the definition of a Free Appropriate Public Education is described in Section IV.

B. Individualized Education Program

* The EHA rights of a free appropriate public education in the least restrictive environment are stated for each handicapped child in an "individualized education program," or "IEP." An IEP is the basic document used to plan and provide EHA programs and services.

* An IEP is a written statement for each handicapped child. It must be reviewed and updated at least annually. It must be prepared by a committee, whose membership is outlined in the regulations (34 C.F.R. Section 300.343(a); .344-.345). The IEP writing committee (called by many different names) will include a school district administrator, a teacher, a parent representative, a person trained in the evaluation of handicapping conditions (often a school psychologist), the parents of the child, and any other persons who have knowledge of the child's special education and related services needs. Each state may set their own additional requirements for membership on the IEP committee.

* The EHA and regulations state what must be contained in an IEP. There must be:

(A) a statement of the present levels of educational performance of such child;

(B) a statement of annual goals, including short term instructional objectives;

(C) a statement of the specific educational services (special education and related services) to be provided to such child, and the extent to which such child will be able to participate in regular educational programs;

(D) the projected date for initiation and anticipated duration of such services, and

(E) appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether instructional objectives are being achieved (20 U.S.C. Section 1401(19); 34 C.F.R. Section 300.340-.349).

V. What Makes The EHA An Assistive Technology Funding Resource?

A. Introduction

* The EHA expressly states that it is a resource for assistive technology devices and services. First, in August 1990, the Office of Special Education Programs issued a policy statement that "assistive technology" must be considered as part of the process of developing a child's IEP. The OSEP position could not be more clear:

> A determination of what is an appropriate educational program for each child must be individualized and must be reflected in the content of each child's IEP. Each child's IEP must be developed at a meeting which includes parents and school officials (34 C.F.R. Section 300.343-300.344). Thus, if the participants on the IEP team determine that a child with handicaps requires assistive technology in order to receive [a] FAPE, and designate such assistive technology as either special education or a related service, the child's IEP must include a specific statement of such services, including the nature and amount of such services. 34 C.F.R. Section 300.346(c); App. C to 34 C.F.R. Part 300 (question 51).

Letter dated August 10, 1990, from J. Schrag to Susan Goodman ("August 10, 1990 OSEP Letter"):

* Then, at the end of the 1990 congressional session, the EHA was "reauthorized". The EHA Amendments of 1990 reinforce the OSEP letter by adding broad definitions for both "assistive technology device" and "assistive technology service" (20 U.S.C. Sections 1401 (a) (25); and (a) (26)). With these statutory definitions, advocates for children can cite specific provisions of the EHA, as well as the OSEP letter to insist on having appropriate assistive technology made part of the child's IEP.

The term "assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

> The term "assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology service. Such term includes:
>
> (A) the evaluation of needs...including a functional evaluation...in the individual's customary environment;

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

AUG 10 1990

Ms. Susan Goodman
Lawyer/Consultant
18182 Headwaters Drive
Olney, Maryland 20832

Dear Ms. Goodman:

This is in response to your recent letter to the Office of Special Education Programs (OSEP) concerning obligations of public agencies under Part B of the Education of the Handicapped Act (EHA-B) to provide assistive technology to children with handicaps.

Specifically, your letter asks:

1. Can a school district presumptively deny assistive technology to a handicapped student?
2. Should the need for assistive technology be considered on an individual case-by-case basis in the development of the child's Individual Education Program?

In brief, it is impermissible under EHA-B for public agencies (including school districts) "to presumptively deny assistive technology" to a child with handicaps before a determination is made as to whether such technology is an element of a free appropriate public education (FAPE) for that child. Thus, consideration of a child's need for assistive technology must occur on a case-by-case basis in connection with the development of a child's individualized education program (IEP).

We note that your inquiry does not define the term "assistive technology" and that the term is not used either in the EHA-B statute or regulations. The Technology-Related Assistance For Individuals With Disabilities Act of 1988, Pub. L. 100-407, contains broad definitions of both the terms "assistive technology device" and "assistive technology service." See Section 3 of Pub. L. 100-407, codified as 29 U.S.C. 2201, 2202. Our response will use "assistive technology" to encompass both "assistive technology services" and "assistive technology devices."

Under EHA-B, State and local educational agencies have a responsibility to ensure that eligible children with handicaps receive FAPE, which includes the provision of special education and related services without charge, in conformity with an IEP. 20 U.S.C. 1401(18); 34 CFR §300.4, (a) and (d). The term "special education" is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child . . . ." 34 CFR §300.14(a). Further, "related services" is defined as including "transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education." 34 CFR §300.13(a).

The EHA-B regulation includes as examples 13 services that qualify as "related services" under EHA-B. See 34 CFR §300.13(b)(1)-(13). We emphasize that this list "is not exhaustive and may include other developmental, corrective, or other supportive services ... if they are required to assist a handicapped child to benefit from special education." 34 CFR §300.13 and Comment. Thus, under EHA-B, "assistive technology" could qualify as "special education" or "related services."

A determination of what is an appropriate educational program for each child must be individualized and must be reflected in the content of each child's IEP. Each child's IEP must be developed at a meeting which includes parents and school officials. 34 CFR §§300.343-300.344. Thus, if the participants on the IEP team determine that a child with handicaps requires assistive technology in order to receive FAPE, and designate such assistive technology as either special education or a related service, the child's IEP must include a specific statement of such services, including the nature and amount of such services. 34 CFR §300.346(c); App. C to 34 CFR Part 300 (Ques. 51).

EHA-B's least restrictive environment (LRE) provisions require each agency to ensure "[t]hat special classes, separate schooling or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." 34 CFR §300.550(b)(2); see also Analysis to Final Regulations published as Appendix A to 45 CFR Part 121a, 42 F.R. 42511-13 (August 23, 1977). Assistive technology can be a form of supplementary aid or service utilized to facilitate a child's education in a regular educational environment. Such supplementary aids and services, or modifications to the regular education program, must be included in a child's IEP. Id. Appendix C to 34 CFR Part 300 (ques. 48).

In sum, a child's need for assistive technology must be determined on a case-by-case basis and could be special education, related services or supplementary aids and services for children with handicaps who are educated in regular classes.

I hope the above information has been helpful. If we may provide further assistance, please let me know.

Sincerely,

Judy A. Schrag

Judy A. Schrag, Ed.D
Director
Office of Special Education
Programs

(B) purchasing, leasing or otherwise providing for the acquisition of assistive technology devices...;
(C) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing of assistive technology devices;
(D) coordinating with other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
(E) training or technical assistance for an individual with disabilities, or, where appropriate, [his/her] family...;
(F) training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other[s] who provide services to, employ, or are otherwise, substantially involved in the major life functions of individuals with disabilities.

* The importance of these statements, first in policy and immediately thereafter in the law, cannot be discounted. The EHA is one of the most important programs affecting the lives of children. No other program offers services with comparable intensity and duration. Children may participate in EHA programs for 5-6 hours per day (or longer), 180 days per year (or year round), from birth to age 21. These years constitute the "developmental" period, in which the greatest amount of the child's physical, cognitive, social and emotional growth will occur. It also is the period in which the child will have the greatest potential to develop skills and prevent or lessen their handicapping conditions.

* Public school education programs have been recognized as the most important government benefit program in terms of creating opportunities for persons with handicaps to be integrated in both their local communities, and the economy. With the addition of assistive technology, the potential benefits of EHA programs expand even further.

B. General Program Criteria Supporting Funding:

* The proper interpretation of the OSEP letter and the 1990 EHA Amendments is that the EHA now expressly states it will fund assistive technology devices and services.

* The EHA contains six programs, services and administrative provisions that should all be viewed as supporting assistive technology funding:

"Free Education" "Least Restrictive Environment"

"Special Education" "Procedural Safeguards"

"Related Services" "Staff Development"

Each of these terms is described below.

C. General Program Criteria Perceived As Funding Barriers

* Even though the EHA must fund assistive technology, there still are potential barriers for securing funding for any individual child. State Tech Act staff will face great challenges in integrating assistive technology into state and local EHA programs. Three of these potential barriers include:

"Appropriate Education"

"A Lack of Basic Knowledge"

"EHA Funding Levels"

"Ownership"

Each of these issues is described below.

1. "Free Education"

* The "Free" in FAPE is extremely significant with regard to children with handicaps who may require assistive technology. As stated in the EHA and regulations, all aspects of the special education and related services provided to a child must be "at no cost to the parents." This term is interpreted broadly.

* The "at no cost" rule prohibits school districts from refusing to include equipment, services or programs on the IEP based on its expense. And, once stated on the IEP, the school district must provide the equipment, services, and program needed to provide a FAPE.

* The only time "cost" can be taken into consideration is where two alternatives exist that would each enable the child to receive an "appropriate" education. In that circumstance, the district may choose the less expensive option.[17]

* If school districts must provide a FAPE in a cost-blind manner, immediate attention will be directed to opportunities for cost-shifting to other sources. Among the most obvious sources are the parents' themselves, private health insurance policies, and Medicaid.

a. Schools Cannot Require Parents To Pay For A Child's IEP

* School districts cannot evade the "at no cost to parents" rule by telling parents they must pay for the needed equipment, services, or programs themselves. One argument is that the time the service is provided is not important; because it can be provided after school, using community resources, the school is therefore not obligated to provide it. This approach violates the "at no cost to parents" rule.

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[17] This rule is unlikely to be acknowledged by school district or state education officials. As noted, the cost of special education programs will almost invariably enter into conversations about an individual child's program, and about school district and/or state education policy.

* Schools also cannot evade the "at no cost to parents" rule by refusing to provide needed equipment on the basis that the child can bring the device from home.

* Likewise, schools cannot attempt to use the state truancy laws to force parents to provide needed mobility devices or transportation, which if not provided would result in the child's absence (see *EHLR* 213:211, OSEP April 20, 1989, annexed).

* Finally, schools cannot claim that a particular service identified as an EHA "related service" is needed, but for "medical" as opposed to "educational," reasons. Congress identified a wide range of "health" services as educationally "related;" school districts are not free to ignore or evade that designation. Once a service is identified as being "needed" for the child to benefit from his/her special education program, then the service must be provided by the schools (The only alternative is for the school to argue that the service is not needed at all).

b. Schools Cannot Require Parents' Health Insurance To Pay For A Child's FAPE

* Since 1980, the U.S. Department of Education has stated that school districts are absolutely forbidden from requiring the parents of a handicapped child to use private insurance proceeds to pay for required services where the parents would incur a financial loss. In addition, even if it could be established that no such loss would occur, coercion still is forbidden: the use of insurance proceeds must be voluntary (*Notice of Interpretation*, 45 Fed. Reg. 86,390 Dec. 30, 1980).

* The U.S. Department of Education reported in research findings that 73% of all health insurance policies had lifetime dollar caps; 71% had annual or lifetime limits on coverage for specific services; that claims use affected future insurability; and that claims use raised future insurance costs. On the basis of this research, OCR restated the validity of the 1980 interpretation (see 16 *EHLR* 963 (OCR 1990); *EHLR* 213:211, OSEP April 20, 1989).

* The possibility that a "cost" will be associated with use of an insurance policy can be both explicit, and implicit. For example, a policy may cover durable medical equipment, as well as other services that may be EHA related services. However, the policy also may include caps on coverage, deductibles, co-payment responsibilities, or other express or subtle limitations that would constitute a "cost" or "financial loss" if the policy were used for services in school. Care must be taken to ensure that a policy does not have such a limitation before a parent considers using his or her insurance to pay for equipment or services that would otherwise be the responsibility of a local school district.[8]

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[8] In addition, insurance companies are well aware of the "at no cost to parents" rule and its implications for private insurance. Many have created barriers in policies to preclude their use for school related equipment or services. These barriers would make it impossible to access the policy for school related services even as a completely voluntary decision by parents. Among the restrictions that may be stated in a

person who is in the recipient's jurisdiction." 34 C.F.R. Sec. 104.33(a) (July 1, 1987). Since the resident district has ultimate responsibility for ensuring that all handicapped students who reside in its jurisdiction receive appropriate educational opportunities, it is thus unclear whether a state could require the district to delegate this responsibility to another district.

To facilitate "choice" legislation being enacted in Nebraska and other states, it is important that this conflict be resolved. Accordingly, we are requesting an opinion from the Department of Education regarding whether a state can require a resident district to delegate to a non-resident district its responsibility to ensure that all handicapped students who reside in its jurisdiction receive appropriate educational opportunities. It would be helpful if we could meet with you and representatives from your office to discuss this matter further. We will call your office in the next few days to see if such a meeting is possible. Thank you in advance for your assistance.

Text of Response

Secretary Cavazos has asked me to respond to your request to meet over the above-referenced matter. As discussed in the telephone conversation between you and Dr. Chassy, we will study the ramifications of "choice" legislation on compliance with Federal regulations governing the education of children with disabilities. During our study we will consult with all necessary Department personnel to ensure that the positions we develop reflect the broad and varied concerns that have bearing upon this issue. Upon conclusion of our study we will share with you our thoughts and arrange a meeting with you at the appropriate level to address any issues you believe require further development.

We appreciate your bringing this matter to the attention of the Department and the cooperation you and your colleagues have provided thus far. We look forward to reaching a position on this matter that reflects the best interests of your client and of all children with disabilities.

Patricia McGill Smith
Acting Assistant Secretary

Inquiry by: John F. Stohrer
Division of Instructional Services
Bureau of Special Education Services
101 Pleasant Street
Concord, NH 03301

Digest of Inquiry
(February 24, 1989)

- Is a district operating within the intent of EHA-B if it requires a non-ambulatory child's attendance using a wheelchair supplied by a third-party insurer?
- Is a district operating within the intent of EHA-B if it enforces state truancy statutes for nonattendance due to parents' refusal to supply an insurer-provided wheelchair for student's in-school mobility?

Digest of Response
(April 20, 1989)

District May Not Require Use of Private Insurance for Wheelchair

A district may not require the parents of a non-ambulatory child to use private insurance proceeds to pay for a wheelchair the student requires for in-school mobility where they would incur a financial loss, but the parents' refusal to consent to use private insurance proceeds does not relieve the district of its obligation to provide a needed wheelchair.

District May Not Use Truancy Law to Make Parents Provide Wheelchair

If the parents of a non-ambulatory student refuse to supply an insurer-provided wheelchair for the child's in-school mobility, a district may not use a state truancy statute to shift the responsibility for providing this related service to the parents; the district remains obligated to provide a wheelchair at public expense and without charge to the parents.

Text of Inquiry

Thank you for your recent response to the inquiry regarding the obligation of a district when a wheelchair is necessary for a non-ambulatory child.

The second part of the inquiry concerned the district's obligation when a parent refuses to send the child's wheelchair to school. You cite 34 CFR 300.13(b)(13)(ii)(iii) in indicating that a a district ". . . may be required to provide a wheelchair for transportation purposes while the child is receiving special education." Your response begs a further question because of the provisions of 34 CFR 300.301, which permits alternative sources of support in meeting the requirements of a free, appropriate, public education. Specifically, the regulation states,

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> Each state may use whatever State, local, Federal, and private sources are available in the State to meet the requirements of this part.
>
> Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a handicapped child.

Assuming a non-ambulatory child has been provided a wheelchair by a third-party insurer,

A. Is a district operating within the intent of P.L. 94-142 if it requires the child's attendance using the wheelchair supplied by the insurer?

B. Is a district operating within the intent of P.L. 94-142 if it enforces State truancy statutes for non-attendance resulting from parent refusal to supply an existing, insurer-provided wheelchair for in-school mobility?

I recognize that issues become quite complex when attempting to interpret statutes and regulations, but since that is our assignment and districts seek our counsel, we must respond.

Your prompt attention is appreciated.

Text of Response

Thank you for your letter with further questions regarding the obligation of a district, under Part B of the Education of the Handicapped Act (EHA-B), when a wheelchair is necessary for a non-ambulatory child. Specifically, you want to know, assuming a non-ambulatory child has been provided a wheelchair by a third-party insurer:

> (a) Is a district operating within the intent of EHA-B if it requires the child's attendance using the wheelchair supplied by the insurer? and
>
> (b) Is a district operating within the intent of EHA-B if it enforces State truancy statutes for non-attendance resulting from parent refusal to supply an existing insurer-provided wheelchair for in-school mobility?

EHA-B places an affirmative duty on school districts to provide children with handicaps a free appropriate public education (FAPE), which includes special education and related services at public expense without charge to the parent or guardian. 20 U.S.C. Sec. 1412(2)(B), 1401(18); 34 CFR Sec. 300.4(a). In meeting the "without charge" require-[illegible] States may use whatever State, local, Federal, and [illegible]te sources of support that are available in the State for meeting EHA-B requirements. 34 CFR Sec. 300.301(a).

In 1980, the Department issued a Notice of Interpretation on the use of parents' insurance proceeds, published at 45 FR 86390 (Dec. 30, 1980) (copy enclosed). [Not reproduced.] Under this interpretation, which remains the Department's current policy, it is impermissible for public agencies responsible for the education of a child who is handicapped to require the parents of that child to use private insurance proceeds to pay for required services where the parents would incur a financial loss. In addition, the use of a parent's insurance proceeds under these circumstances must be voluntary. A parental refusal to consent to the use of parents' private insurance proceeds does not relieve the public agency responsible for the education of the child from the duty to provide required services included in the child's individualized education program. Therefore, if a wheelchair is found to be a required related service under 34 CFR Sec. 300.13, the public agency must provide the service "at public expense . . . and without charge," 34 CFR Sec. 300.4(a), regardless of whether or not the parents possess their own wheelchair or can obtain one through the use of insurance benefits. Accordingly, a public agency is not permitted under the EHA-B to use the State truancy statutes to shift responsibility for providing related services to an eligible child's parents.

We have provided only these general comments on the questions you posed because the specific circumstances under which the wheelchair was obtained are not provided in your letter. Also, as we indicated in our earlier letter on this topic, the due process procedures under EHA-B are available to the parent and the public agency to determine the relative rights and duties of school officials and parents in such cases. *See* 34 CFR Secs. 300.500 - 300.514.

I hope that the above information is of assistance. If this office can be of further service, please let me know.

Patricia McGill Smith
Acting Assistant Secretary

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- This provision does not preclude school districts from asking parents whether they have any insurance coverage, but school districts have no authority to require parents to disclose those policies, or to permit school authorities to review them.[19]

c. Schools Can Use Medicaid To Pay For A Child's FAPE

- The interrelation between the "at no cost to parents" rule, and a child who is eligible for Medicaid is more complicated.

- First, any use of Medicaid funds will be limited to those children who are eligible for Medicaid. In addition, just as with the limitations on use of insurance proceeds, schools cannot force parents to state their children are Medicaid eligible, or force them to use Medicaid to aid their child's education. Medicaid utilization must be voluntary.

- If Medicaid can be considered, there are tremendous opportunities for schools to shift the costs of many related services. Since 1986, Congress has enacted three laws that create obligations for Medicaid to provide and/or reimburse school districts for the costs of special education and related services for children who are Medicaid eligible.

- In Public Law 99-457, Congress acknowledged that funding systems other than the EHA may be tapped to pay for the programs and services required by handicapped children (20 U.S.C. Section 1412(6)). The House Report accompanying Pubic Law 99-457 stated:

> Although Public Law 94-142 [the EHA] designated the state educational agency as [being] responsible for ensuring that handicapped children receive a FAPE ... it did not make the educational agency solely financially responsible for all services provided.

The House Report went on to specifically identify Medicaid as one of the other financially responsible programs.

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policy are express coverage exclusions for 'services that can otherwise be obtained at no costs to parents,' 'services that can be obtained during the hours when school is in session,' or services for 'children between the ages of 5 and 21.' A recent federal court challenge to such policy exceptions as a violation of the EHA was unsuccessful.

[19] The limits on the use of insurance exist despite the language in the EHA regulations which might suggest different conclusions. 34 C.F.R. Section 300.301(b) states that:

> Each state may use whatever Federal, State, local and private sources are available in the State to meet the requirements of this part.
>
> Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or pay for services provided to a handicapped child.

- In the Medicare Catastrophic Coverage Act, Public Law No. 100-360 (1988), Congress amended the Medicaid Act to expressly make Medicaid responsible to provide reimbursement for all related services stated on a Medicaid eligible handicapped child's IEP, which also are covered services under the State Medicaid Plan (42 U.S.C. Section 1396b). (Although Congress later repealed most of the Medicare provisions of this law, this Medicaid provision remained unchanged.)

- The Omnibus Budget Reconciliation Act of 1989 ("OBRA-'89"), expanded Medicaid's obligations once again. OBRA '89 amended the terms of the mandatory Medicaid service known as "Early Periodic Screening, Diagnosis & Treatment" or ("EPSDT"). Effective April 1, 1990, children younger than 21 are entitled to receive Medicaid reimbursement for services beyond the state Medicaid plan, to include any service for which the federal government would provide reimbursement (42 U.S.C. Section 1396d(r)).

- Read together, the OBRA-'89 and MCCA amendments will enable school districts to obtain reimbursement for any related service on a child's IEP that "could" be reimbursed by the federal government, regardless whether the service is otherwise listed on the state's Medicaid plan.

- These Medicaid amendments make all the provisions of the Medicaid Act that are supportive of assistive technology funding applicable to children between the age 5 and 21. They will apply to related services that are human services, such as occupational therapy, physical therapy, counseling, and speech pathology and audiology. It also will extend to in school nursing, which may parallel Medicaid home health nursing or private duty nursing.[20]

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[20] A caveat is required in regard to nursing services. Medicaid rules for these services include "at home" only location restrictions, which have been interpreted literally to bar in-school nursing coverage. These location restrictions presently are a matter of significant controversy, and non-uniform rules exist throughout the country. Tech Act staff must review each state's Medicaid program carefully, taking into consideration the numerous lawsuits, rules changes and interpretations, and waivers that may affect nursing services.

For example, in Massachusetts, the Medicaid private duty nursing regulations were amended in May 1990 to permit nurses to go to school. In Maryland, children covered by a Medicaid waiver have the same rights.

In addition, a lawsuit in New York has resulted in new rules that eliminate any location restrictions on Medicaid private duty nursing services. Because the decision was issued by the federal court of appeals, these rules also will apply to children in Vermont and Connecticut. Another lawsuit, in Connecticut, has required Medicaid to provide an in-school nurse through the Medicaid home health nursing rules.

Unfortunately, the federal government refuses to apply these decisions nationally. For this reason, both lawsuits are now being re-drafted as nation-wide class actions. Tech Act staff must inquire whether their particular state will apply the "at home" location restrictions for these nurses.

A separate controversy exists regarding in-school nurses under the EHA. Lawsuits in New York, Pennsylvania, Ohio and Michigan sought to have the EHA related service "school health services" be interpreted to require individualized nursing services for severely handicapped children. To date, two decisions have called nurses related services, and two have concluded they are not. However, none of these cases has been a class action, and all but the New York decision was decided by a U.S. District Court. The New York decision, which held nurses were not a related service, is applicable to that state, and Vermont

They also will apply to items of durable medical equipment, such as wheelchairs, augmentative communication devices, health monitoring equipment, hearing aids, vision aids, etc.

- For states that have very limited-scope Medicaid programs, these three amendments create significant expansions of the funding and services available to handicapped children in school.

- These amendments represent a potentially significant means for school districts to shift the costs of their related services. Nonetheless, schools may be hesitant to take advantage of the Medicaid program. Possible explanations include the duty of the school to place the service and/or device on the child's IEP. Schools may be hesitant to add expensive new equipment, programs or services to an IEP, notwithstanding the present availability of Medicaid. The school district is bound to implement the IEP as written, and must provide all listed services and equipment. If Medicaid refuses to pay, or the child's Medicaid eligibility ceases, the school district will be required to pay.[21]

- A limiting factor regarding Medicaid is that it may not cover all of the costs of the services and/or equipment. Medicaid services have state- or at times, locally-set rates of reimbursement. School districts, by contrast, may contract with or pay related services providers more than the Medicaid reimbursement rate. If so, then Medicaid will be able to provide some, rather than all of the costs of the services. [22]

- Another barrier is that the proof needed to establish Medicaid eligibility is likely to be more demanding than the proof that would support having a service added to a child's IEP. Resolving the differences between these two systems may be a significant challenge. Also, if the school is to seek reimbursement for services it provides with its own staff, then the school may have to apply to be a Medicaid provider and have a rate set for its services.

- An alternative to the schools' seeking reimbursement from Medicaid services and devices listed on the IEP is to ask the child's parent to secure Medicaid services directly, and simply have them be used at school. Such a request raises the same problems as if the school attempted to force a parent to pay for the service directly. However, the school could overcome the problem by working with the parent, and showing how proceeding in this manner will both secure the needed device or service for the child, and eliminate

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and Connecticut. The other decisions, however, do not have mandatory state- or region-wide effect.

[21] Overcoming schools' hesitance to use Medicaid may take some time. Tech Act staff may suggest that schools first use Medicaid to reimburse for services already on an IEP, such as speech, occupational, or physical therapy. If that experience is successful, schools may be more willing to risk adding expensive assistive technology devices to the IEP.

[22] The state legislature may impose other limitations on the rate of reimbursement. In New York, for example, state law authorizes school districts to receive only the federal share of the Medicaid expenses, 50% for that state. The state and local share will not be reimbursed to the school district.

administrative burdens on the school. For example, a child's IEP could state that a child receive an augmentative communication device or a power wheelchair, and the school could then seek Medicaid reimbursement. Or, the school could ask the child's parent to seek direct Medicaid payment for these items of durable medical equipment, and then have the child take the devices to school.

- Regardless whether there are any alternative funding sources, schools must provide a FAPE at no costs to the parents, including any assistive technology that is stated on the child's IEP.

2. Special Education

- "Special education" is defined in the EHA as:

> **specially designed instruction,** at no cost to parents or guardians, to **meet the unique needs of a handicapped child,** including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions (20 U.S.C. Section 1401(16)).[23]

- The key part of the definition of "special education" is that the instruction be "specially designed" to "meet the unique needs" of a particular child. The word "**appropriate**" is most often used to describe the individualization of the instruction.

- Based on the child's needs, the "special design" may be quite minimal, or extensive. For instruction to be "specially designed" the child does not have to be in a separate class. For some children, the specially designed instruction will be required for all aspects of their education. For others, e.g., a child with a physical impairment, specially designed physical education may constitute all of his or her special education. All the remainder of the child's education would be the same as that provided to all other students (see 34 C.F.R. Appendix C (Qn. 47)).

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[23] The EHA regulations expand this definition to include:

> The term includes speech pathology, or any related service, if the service consists of specially designed instruction, at no cost to the parents, to meet the unique needs of a handicapped child, and is considered special education rather than a related service under state standards.
>
> The term also includes vocational education (e.g. industrial arts and consumer and homemaking education programs) if it consists of specially designed instruction, at no cost to the parents, to meet the unique needs of a handicapped child (34 C.F.R. Sections 300.14(a); 300.305).

The EHA regulations also state detailed definitions of "physical education." Physical education includes the development of physical and motor fitness, motor development (e.g. development of fundamental motor skills and patterns), movement education, and "adapted physical education" (34 C.F.R. Sections 300.14(b)(2); 300.307).

* Another characteristic of special education is that school districts do not satisfy their duty to provide special education by attempting to rely on staff or programs that presently are, or once were "available." Rather, school districts must hire trained, state-licensed staff, obtain equipment and services, and create programs that are based on the needs of each handicapped child. That a particular district has never been called on to serve a particular need, or that the district always has 'done it this way,' is not consistent with its EHA special education mandate.

* The August 10, 1990 OSEP letter states expressly that a child's special education may include the provision of assistive technology. The area of greatest potential expansion is the use of computers in school. Specially designed instruction may be available through the use of computer software, requiring the addition of a computer as well as the program to the child's IEP. The child's special education can include both instruction in basic operation of the computer, as well as the substantive instruction through the software (see *EHLR* 213:186, OSEP Dec. 14, 1988; 213:269, OSERS July 10, 1989).[34]

* Many states have educational computing initiatives, with purchased and/or donated equipment and software being distributed throughout the state. These initiatives most often are described as aiding teachers and students meet the technological challenges of the 21st century. Rarely, however, are they described in terms of the potential that computers and software can have in meeting the integration goals of the EHA.
Yet both the EHA and Section 504 require that children with handicaps, and the teachers of these children have equal access to all computer services available in the state.

* Computer aided education for children with handicaps can meet all of the EHA integration goals. For example, this instruction may allow a child to be physically and academically integrated in "mainstream" in "regular" education, learning the same materials as the rest of the class. This may apply to children with severe physical handicaps, or severe learning disabilities. The computer will be able to put the curriculum in a form the child can access: it can allow a child who cannot hear or cannot process oral instruction to read lessons; it can speak to the student who cannot effectively read, see or process instruction presented in written form; and it can allow a student who cannot write to use the computer as a notebook. The specially designed instruction for these students may not require the adaptation of the content of the curriculum, only its manner of presentation.

* Another possible use of computer assisted education is to allow a child to remain physically and academically, and socially integrated by altering the content of the curriculum. Children with varying degrees of intellectual handicaps can benefit enormously from these opportunities. The computer can become the child's teacher, allowing learning to progress along the same lines as the general class, but at the individual child's pace, or level of understanding.

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[34] School districts are free to spend up to $5,000 per item for new equipment without seeking "prior approval" for any purchase. Child specific computer aided instruction, or most assistive technology, is unlikely to reach that threshold (34 C.F.R. Section 80.32; 16 *EHLR* 962 OSEP 1990).

Inquiry by: Department of Special Education
George Peabody College for Teachers
Vanderbilt University
Nashville, TN 37203

Digest of Inquiry
(November 1, 1988)

- May special education and related services be provided at no cost to handicapped students placed by their parents in parochial schools and facilities even if the local education agency has made available a free appropriate public education?

- Under federal law, is there a mandate to provide to handicapped children specialized equipment or materials, other than that required for special transportation?

- Do materials exist on reconciling special education mandates with the Establishment and Free Exercise clauses of the Constitution in regard to the planning and delivery of special education and related services to handicapped children in parochial schools and facilities?

Digest of Response
(December 14, 1988)

blic Agency Must Offer FAPE to Private School Children

If a handicapped child has available a FAPE and the parents place the child in a private school or facility, the public agency is not required to pay for the child's private education. However, the public agency is required to make services available as provided in the Education Department's General Administrative Regulations (EDGAR).

Funding for Equipment for Private School Children

The extent to which EHA-B funds are available to provide specialized equipment to handicapped children enrolled by their parents in private schools depends largely on the needs of individual children for such aids and the public agency's budget for its EHA-B funds. For children provided a FAPE, a public agency must ensure that they get the services and aids required to assist them to benefit from special education and placement in the least restrictive environment.

Services to Students in Sectarian Facilities

The U.S. Department of Education addressed planning and providing instructional and related services to handicapped children in parochial schools and sectarian facilities in a September 12, 1985 policy letter ng that since the Supreme Court has set no litmus for permissible aid to students in religiously-oriented schools, the Department believed that Chapter 2 funds may still be used for equipment and materials placed on private school premises. School officials were advised to carefully review, and modify if necessary, instructional services provided on private school premises under Chapter 2 in light of the Court's decision in *Aguilar v. Felton*, barring instructional services in private religious school buildings under Chapter 1. However, a ban against on-premises instructional services to private school children under EHA was not favored since it might prevent the delivery of statutorily required services.

Text of Inquiry

My students and I are trying to determine how related services can be delivered to children in parochial schools consistent with the establishment and free exercise clauses of the 1st Amendment.

1. Are we correct in determining that consistent with their number and location special education and related services must, without cost to the parents, be provided to children placed by the parents in parochial schools and sectarian settings even if the local education agency has available free appropriate public education in the public agency?
2. Other than specialized equipment required to provide special transportation, is there a mandate to provide specialized equipment or materials to handicapped children pursuant to federal law?
3. What are the positions, guidelines, opinions, or other materials you can provide us regarding reconciling special education mandates with the establishment and free exercise clause in planning and providing special education and related services to children in parochial schools and sectarian settings?

Text of Response

Thank you for your letter concerning the rights of private school children who are handicapped to participate in special education services. The regulations you cite in your letter, 34 C.F.R. Secs. 300.403 and 300.450-300.452, are supplemented by 34 C.F.R. Secs. 76.651-76.662, which are incorporated by reference in 34 C.F.R. Sec. 300.451(b). These additional regulations, which are part of the Education Department General Administrative Regulations (EDGAR), determine the rights of students enrolled in private schools to a genuine opportunity for equitable participation in public school services. Here are our specific responses to the questions you asked:

1. Are we correct in determining that consistent with their number and location special education and

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related services must, without cost to the parents, be provided to children placed by the parents in parochial schools and sectarian settings even if the local education agency has available free appropriate public education in the public agency?

Response: If a handicapped child has available a free appropriate public education (FAPE) and the parents choose to place the child in a private school or facility, the public agency is not required to pay for the child's education at the private school or facility. However, the public agency would have to make services available as provided by the EDGAR regulations cited above. 34 C.F.R. Secs. 300.403(b), 300.451(b) and 76.651-76.662.

2. Other than specialized equipment required to provide special transportation, is there a mandate to provide specialized equipment or materials to handicapped children pursuant to federal law?

   Response: Funds under EHA-B may be used for materials and, with prior approval of the grantor agency, for equipment. *See* 34 C.F.R. Part 74, Appendix C. The extent to which EHA-B funds will be available to provide specialized equipment or materials to children with handicaps enrolled in private schools by their parents will depend largely on the needs of individual children for those aids and the circumstances of the public agency with respect to the amount and approved budgeting of its EHA-B funds. In the case of children who are provided FAPE, a public agency must meet that requirement by ensuring that those children receive the services and aids that are required to assist them to benefit from special education and to be placed in the least restrictive environment. 34 C.F.R. Secs. 300.13(a) and 300.550.

3. What are the positions, guidelines, opinions, or other materials you can provide us regarding reconciling special education mandates with the establishment and free exercise clause in planning and providing special education and related services to children in parochial schools and sectarian settings?

   Response: The position of the U.S. Department of Education on this matter is addressed in former Secretary Bennett's letter to the Honorable Wayne Teague (dated September 12, 1985). A copy of that letter is enclosed for your review [Not reproduced].

We hope you find this information helpful.

G. Thomas Bellamy, Ph.D.
Director
Office of Special Education Programs

Inquiry by: Randy Soffer, Ph.D.
Texas Education Agency
Special Education Programs
1701 North Congress Avenue
Austin, TX 78701-1497

Digest of Inquiry
(November 30, 1988)

- May participants in an IEP meeting meet via computer conferencing instead of face-to-face?
- Is anyone currently using or exploring computer conferencing for developing IEPs?

Digest of Response
(January 26, 1989)

IEP Meeting May Be Held Via Computer Conferencing If Parties Agree

EHA regulations permit the use of alternative methods for including all required participants in IEP meetings, so if the public agency, the child's parents, and any other required participants all agree, an IEP meeting may be held via computer conferencing, if the decision to use this alternative method is made on a case-by-case basis.

OSEP Knows of No Current Use of Computer Conferencing for IEP Meetings

OSEP is not aware of any agency that is currently using or exploring the use of computer conferencing for developing IEPs.

Text of Inquiry

Linda Glidewell suggested that I write to you concerning an issue that has recently surfaced. I am interested in a clarification related to individualized education program (IEP) meeting requirements. Specifically, I am wondering if it is always necessary for IEP meeting participants to meet face-to-face or is it possible, under the regulations, for participants to "meet" via a computer conferencing mode? If computer conferencing is acceptable, do you know of anyone using or exploring this mode?

The reason these questions are being raised is that we are exploring some options for increasing the efficiency of school staff planning activities and want to ensure that our efforts are in compliance with federal regulations. I look forward to hearing from you.

Text of Response

Thank you for your letter regarding the requirements in Part B of the Education of the Handicapped Act (EHA-B) for [illegible] scope of the LEA's responsibility includes those "private school handicapped children" who reside in the LEA, if the LEA provides public school programs to children with handicaps in that age range. The nature of that responsibility, however, is not the same as the LEA's responsibility to publicly-placed children with handicaps.

While a school district must make special education and related services available to children with handicaps enrolled in private schools who are not publicly-placed or referred, the right to be provided special education and related services is not an individual right of every child placed by parents in a private school. Further, an LEA is not required by EHA-B to provide the full range of EHA-B services to those children with handicaps enrolled in private schools it elects to serve. In sum, if a local school district services students with handicaps, and the students are provided with speech services at the school they attend, or are provided transportation to the site where services are available, the private school students receiving speech services are entitled to transportation, if needed, to the site where the services are provided.

Your letter also makes reference to an inquiry from [ ] to which our response was pending. A copy of the Department's response to [ ] is enclosed. For additional information on how Mississippi implements the EDGAR private school requirements you may contact Ms. Carolyn Black at the Mississippi State Department of Education, P.O. Box 771, Jackson, Mississippi 39205; telephone: (601) [illegible]-3498.

We hope you find this information helpful.

Judy A. Schrag, Ed.D. Director
Office of Special Education Programs

Honorable Lee H. Hamilton
House of Representatives
Washington, D.C. 20515

Digest of Inquiry
[Date Not Provided]

- May districts spend money on non-mandated activities, such as recreation or music programs, while spending less than the mandated amount for special education programs?
- Are there federal regulations concerning the use of computers or other "cutting edge" technological equipment by disabled students; and are districts required to provide disabled students with access to computers?
- How does ED allocate EHA-B funds to states and local districts; and how much flexibility do school boards have in expending these special education funds?
- Are there any federal efforts underway to help reduce the costs of equipment for disabled students; and are competitive bids required for providers of such equipment?
- Why are some districts able to meet the requirements of the EHA while other districts are not?

Digest of Response
(July 10, 1989)

Expenditure of EHA-B Funds

The EHA does not mandate specific amounts to be spent on certain types of special education and related services provided to eligible children. Districts submit EHA-B applications to SEAs for approval of budgets and specific activities, and the federal government audits expenditures of EHA-B funds to assure that those funds are properly expended.

Computers May be Related Service

Computers may be related services necessary to provide FAPE for some children. Also, ED provides Part G grants for projects involved with the development of technological equipment for disabled students.

OSEP Explains EHA-B Funding Procedures

EHA-B funds are disbursed to states based on an annual child count of the number of eligible children who are receiving special education and related services. Thereafter, the states make subgrants to local districts based on a distribution formula and conditioned on the approval of a local application.

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> These letters have been edited to eliminate extraneous and irrelevant material.

States May Receive Technology Related Assistance Grants

EHA-B funds are generally not used for the purchase of specialized equipment; however, the Technology Related Assistance for Individuals with Disabilities Act of 1988 will provide grants to states to establish technology-related assistance programs.

OSEP Cites Factors Affecting State Compliance with EHA

ED's latest Annual Report to Congress lists two major problems affecting district's compliance with the EHA: ineffective state monitoring procedures and states' failure to properly supervise local special education programs. Another factor affecting compliance is the lack of appropriately trained special education personnel in some states.

Your letter addressed to former Assistant Secretary for Civil Rights LeGree S. Daniels has been referred to this office for reply. In your letter, you requested responses to a number of questions concerning the provision of special education programs. Your question and our answers are as follows:

Q. May school districts spend money on non-mandated activities, such as some forms of recreation or music programs, while at the same time spending less than the mandated amount for special education programs?

A. The primary Federal program that provides financial assistance for the education of the children with handicaps is Part B of the Education of the Handicapped Act (EHA-B). Under this program, the Secretary makes grants to State educational agencies (SEAs) and, through them, to local educational agencies (LEAs) to assist in the provision of a free appropriate public education (FAPE) to children with handicaps. The EHA-B statute and regulations provide that these Federal funds must be spent on special education and related services for children with handicaps. The Federal government audits records of expenditures of EHA-B funds to assure that those funds are expended for allowable costs and in accordance with program requirements. Two specific requirements relating to the use of the EHA-B funds are found at 34 CFR §§ 300.182-300.186 (regarding the excess cost requirement) and 300.230 (regarding the nonsupplanting requirement). LEAs submit EHA-B applications to SEAs for approval of activities and budgets. Otherwise, few specifics are set forth in the EHA-B statute or regulations regarding the types of special education and related services to be provided under EHA-B to eligible children with handicaps.

Q. Does the Department of Education have regulations concerning the use of computers or other "cutting edge" technological equipment by handicapped students? If handicapped students are unable to generate enough free time to work with computers, does a school district have the obligation to provide students with access to computers at another time?

A. The EHA-B regulations do not specifically address the use of computers or other technological equipment. However, the EHA-B does require that each child receive those related services which will enable the child to receive FAPE. Although computers and other technological equipment are not specifically included in the list of related services in § 300.13 of the EHA-B, for some children they may be related services necessary to provide FAPE. Determinations of whether a computer or other type of technological equipment is required to provide FAPE would be made through the individualized educational program (IEP) procedures. If a parent and school district disagree about what services are required to provide FAPE, the parent may request a due process hearing. LEAs may, with prior approval from the State, provide such equipment with EHA-B funds. LEAs may also use EHA-B funds to provide computer time for students with handicaps.

This Office also provides funding, under Part G of EHA, for projects involved with the development of "cutting edge" technological equipment. In addition, a number of studies are under way that are examining how students with handicaps use technology and whether problems of equity exist in this area.

Q. How does the Department of Education determine the level of funding it allocates to States and school districts for students with handicaps? Once allocated, how much flexibility does a school board have in determining how funds for special education are spent?

A. Under the EHA-B program, funds are disbursed to a State on July 1 for the following fiscal year, if the State has submitted a State plan that is substantially approvable and a child count. The amount of a State's allocation is based on an annual count, taken December 1, of the number of children in the State with handicaps, ages 3 through 17, if the State is participating in the Section 619 EHA program, or ages 6 through 17 if the State is not participating in the Section 619 program, who are receiving special education and related services. 34 CFR 300.701

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▶ These letters have been edited to eliminate extraneous and irrelevant material.

The SEA makes subgrants to LEAs for special education services to children with handicaps that are based on the formula for distribution of these funds set out at 34 CFR §§ 300.706-300.707. Each LEA seeking EHA-B funds for any fiscal year must submit an application for approval to the SEA. The application each LEA submits must include a budget that describes how it will use the funds. LEAs can make budget changes in accordance with the requirements at 34 CFR § 80.390.

Q. Are any efforts underway to help reduce the costs of equipment for the handicapped (i.e., wheelchairs or special vans)? Are competitive bids required for providers of handicapped equipment?

A. Through its research programs, this office funds projects involved with the initial development of some technologies, and every effort is made to focus on a product's usefulness and marketability. A new Federal program which could have an impact on the cost of equipment for individuals who are handicapped is the Technology Related Assistance for Individuals with Disabilities Act of 1988. This program will provide grants to States, on a competitive basis, to establish consumer-responsive, statewide programs of technology-related assistance for individuals of all ages who have disabilities. States may elect to purchase or lend equipment to individuals or to provide loans or other financing for individuals. Grant applications will be due in July 1989, and awards made the following September.

EHA-B funds, on the other hand, generally are used to pay the salaries for personnel providing services to children rather than for the purchase of specialized equipment. When procuring services or equipment, LEAs must follow procedures that are consistent with the requirements of 34 CFR 80.36 of the Education Department General Administrative Regulations (EDGAR).

Q. What is your appraisal of why some school districts are able to meet the requirements of the law regarding handicapped students while other school districts are unable to meet these mandates?

A. In assessing the effectiveness of efforts to educate children with handicaps, this Office analyzes information from a variety of sources, such as reviews of EHA-B State plan applications, studies of State efforts to implement EHA-B requirements, and evaluations of educational programs provided by States and localities. SEAs engage in similar assessment procedures to determine the effectiveness of LEA efforts to meet EHA-B requirements. Our findings in this regard are contained in the Department's Annual Report to Congress on the implementation of EHA. In the latest of these reports, State accomplishments regarding those efforts are highlighted as well as discussions of State deficiencies. Two major problems cited to explain why some local districts have compliance problems are: ineffective State monitoring procedures and failure of the State to meet its obligations for general supervision of all special education programs in the State. Another reason why some districts are not meeting the mandates regarding children with handicaps is the lack of appropriately trained personnel in some States.

I hope that the above information is of assistance. If you have any questions regarding this matter, please contact Ms. Sandra Brotman in the Office of Special Education Programs at (202) 732-1031.

Patricia McGill Smith
Acting Assistant Secretary

Ms. Jeanne Kincaid
Hearings Officer/Legal Specialist
Oregon Department of Education
700 Pringle Parkway SE
Salem, Oregon 97310-0290

Digest of Inquiry
[Date Not Provided]

- **When a disabled child moves from one state to another, is the sending school district required to transfer the child's educational records to the receiving district?**

Digest of Response
(July 10, 1989)

Districts Not Required to Transfer Education Records

The EHA does not require that a sending district in one state provide a receiving district in another state with education records, although such transfer is permitted under both the EHA and FERPA. Parents are the only parties guaranteed access to education records and, also, there is nothing in the EHA or FERPA that obligates parents to provide

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- Increasingly, academic integration for children with cognitive impairments is being pushed into middle and junior high schools, based on the successful integration of these children in the primary grades. Rather than segregating them into self-contained classes, computer aided instruction permits them to continue in regular education classes, with their friends, in their neighborhood school. Success with this type of instruction requires extra teacher preparation and coordination, but it is a clear direction for future special education program design.

- The definition of special education also includes "speech pathology, or any related service, if the service consists of specially designed instruction" (34 C.F.R. Section 300.14(a)(2)). A child who requires an augmentative communication device would receive speech pathology in the form of special education: first, s/he would require specially designed instruction in how to use the device; then the specially designed instruction would expand to include how to assimilate the device into the child's school and home environment.

- The definition of special education also includes adapted physical education. Here, the role of assistive technology may be easier to identify because of the wide availability of physical fitness apparatus for use at home and health clubs. Less well known may be the duty to make equipment available, and as needed, to adapt equipment to allow children with handicaps to use them. Then, school staff must specially design a physical education program that will enable children with handicaps to gain the same benefits from use of the equipment as do other children without handicaps.

3. "Related Services"

- Related services are an essential part of a handicapped child's "appropriate" education. As stated in the EHA, "related services" include, but are not limited to, the following services:

  - transportation;
  - speech pathology;
  - audiology;
  - psychological services;
  - physical therapy;
  - occupational therapy;
  - early identification & assessment of handicapping conditions
  - medical services for diagnostic & evaluation purposes;
  - school health services;
  - social work services;
  - parent counseling & training
  - counseling services;

The term also includes any other developmental, corrective and support services that may be needed by a handicapped child. The EHA regulations expressly state that this list (in contrast to the list of handicapping conditions), is not exclusive (20 U.S.C. Section 1401(17); 34 C.F.R. Section 300.13).

- To receive a related service a child with handicaps must establish that the service is "required to assist a handicapped child to benefit from special education."[25]

* For some children, the dividing line between special education and related services may be difficult to discern. The definition of special education, noted above, acknowledges the overlap, and it is of no eligibility significance in regard to a child's program or services. Some children may have related services constitute the majority of their educational program. As long as the proof demonstrates that the unique needs of the child warrant such a program, the child is entitled to it.

* Equally true is that the need to show that the child requires the related service "to benefit from special education" is not intended to be a barrier to receipt of special education or related services. The Act embodies a "zero reject" policy: no child is too handicapped to benefit from specially designed instruction. All children who meet the EHA definition of handicap, regardless of the severity of their handicaps, are presumed to have needs that can be addressed by specially designed instruction and are entitled to any related services that will assist the special education to meet those needs.

* As with special education, the specific related services a district must make available to a handicapped child will be based on the child's needs. Existing facilities, staff, equipment, services, etc., and past or current practices are not the proper measures as to whether a child can receive a particular related service. Also true is that school districts cannot excuse a failure to provide a needed related service because the staff is alleged to be "unavailable." Even in rural areas, a full complement of related services providers must be available to meet childrens' needs; the burden of making those providers available falls squarely and completely on the local or state education authorities.

* The August 10, 1990 OSEP letter also states that assistive technology can be considered a "related service." Stated below are the specific related services that may support assistive technology. However, if the technology device or service does not "fit" any of these categories, it still can be a related service. The list is not exclusive.

a. "Transportation"

* The EHA lists transportation within the definition of related services (20 U.S.C. Section 1401(17)). The EHA regulations define transportation to include:

(i) travel to and from school and between schools;
(ii) travel in and around school buildings; and
(iii) specialized equipment (such as special or adapted buses, lifts and ramps) if required to provide special transportation for a

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[25] The connection between related services and special education is a mandatory component of the EHA. If the service is needed for reasons other than allowing the child to benefit from special education, then by definition, the service is not an EHA related service (see 34 C.F.R. Section 300.14(comment). However, if the service is needed by a child with handicaps, but not for the purpose of benefitting from special education, i.e., to enable the child to benefit from regular education, the service may be available through the parallel provisions of Section 504 of the Rehabilitation Act.

handicapped child (34 C.F.R. Section 300.13(b)(13)).[24]

- The EHA transportation services are available to children with any type of impairment. The key, as with any related service, is to show that the transportation is needed to enable the child to benefit from his/her special education program. Obviously, a child who requires transportation services in order to get to and from school meets this test, as noted by subdivision (ii) of the definition.

- Handicapped children are entitled to receive transportation services that are different from those provided to other children. It includes door to door transportation, while other children may be excluded from transportation, or be required to get to designated bus stops. For example, if physically handicapped or health impaired children reside in walk up apartments, or live in homes where they are unable to get from their front door to a curb, transportation staff will be required to lift and carry the child to a school bus. For children who are unable to travel by school bus, alternate vehicles may be required.

- Handicapped children who require mobility assistance within school can receive whatever assistive technology devices or services will enable them to get around in the school building. This includes wheelchairs, rails, guides, etc. The device or service must be listed on the child's IEP (see *EHLR* 213:209, OSEP Feb. 17, 1989).

b. Speech Pathology

- The EHA regulations define speech pathology to include:

(i) identification of children with speech or language disorders;
(ii) diagnosis and appraisal of specific speech and language disorders;
(iii) referral for medical or other professional attention necessary for the habilitation of speech and language disorders; and
(iv) provisions of speech and language services for the habilitation of communication disorders.

- Communication skills are among the most important skills taught in school. It is required for academic, social and societal integration. Speech pathology services provide a broad opportunity for assistive technology to be introduced into a school program.

- It includes the acquisition and training on the use of augmentative communication devices. Schools cannot say "we do not think this is necessary" for a non-speaking child any more than Medicaid can say it is not "medically needed."

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[24] In addition to these EHA duties, school districts must comply with other laws that mandate schools make their facilities physically accessible. Architectural barrier removal will complement the school district's EHA transportation duties.

initially provided special education and related services." Under EHA-B, in the absence of a State law requiring parental consent before a handicapped child is evaluated or initially provided special education and related services, the public agency uses the hearing procedures of 34 CFR Secs. 300.506-300.508 "to determine if the child may be evaluated or initially provided special education and related services without parental consent." 34 CFR Sec. 300.504(c)(2). The override provisions of 34 CFR Sec. 300.504(c) do not specifically apply to consent requirements outside of those for evaluations and initial placements. In keeping with the States' general responsibility to ensure that the special education and related services provided to children with handicaps meet the requirements of EHA-B, and its regulations (*see, e.g.*, 34 CFR Sec. 300.600), however, additional State consent requirements must provide for appropriate procedures, consistent with EHA-B, including the right to request due process at any time for resolving the disagreement between parent and public agency. We recommend that States designate the EHA-B due process hearing procedures as the appropriate mechanism for resolving disputes arising from parental consent requirements for situations beyond evaluations and initial placements. Public agencies are not excused from their obligation under EHA-B to provide a free appropriate public education because a parent has withheld consent to a required procedure or action unless the public agency has taken the steps necessary to either resolve the matter through voluntary means acceptable under EHA-B, or through those procedures available for resolving parental withholding of consent.

Our review of these issues and continuing requests for guidance in this area suggests that further regulation on matters addressed by Secs. 300.504(b)(2) and (c) might be appropriate. We are continuing to review whether regulatory changes in this area ought to be proposed.

Thank you for bringing this matter to our attention. I have enclosed a copy of the EHA-B regulations for your easy reference. [Not reproduced] If we may provide further assistance, please let me know.

Patricia McGill Smith
Acting Assistant Secretary

Inquiry by: John Stohrer
Complaint Investigator
Division of Instructional Services
Special Education Bureau
101 Pleasant Street
Concord, NH 03301-3860

Digest of Inquiry
(Inquiry Not Provided)

- Does Pub. L. 94-142 require districts to provide wheelchairs for in-school use by nonambulatory students?
- If parents refuse to send a student's wheelchair to school, or say that a wheelchair is not needed at home because the child is moved by the parents when necessary, what is a district's responsibility?

Digest of Response
(February 17, 1989)

Wheelchair May Be A Related Service

The standard for determining if a wheelchair must be provided as a related service is whether it is required to assist the handicapped student to benefit from special education; related services include transportation for travel in and around school buildings and may include the provision of specialized equipment.

Wheelchair May Be Required for Education-related Transportation

A district is not required to provide a wheelchair for a student's personal use outside of school, but it may be required to provide a wheelchair for transportation purposes while the child is receiving special education.

Text of Response

Thank you for your inquiry requesting responses to the following questions:

1. Does P.L. 94-142 require a school to provide a wheelchair for in-school use by a non-ambulatory child?
2. If the answer to number one is in the negative, what is the school's responsibility if a parent refuses to send the child's wheelchair to school or says that a wheelchair at home is unnecessary because the child is moved physically by a parent when the need arises?

We have also received correspondence from the parent involved with this issue.

EHA-B requires that all children with handicaps have available to them a free appropriate public education (FAPE) which includes special education and related services to meet their unique needs. 20 U.S.C. 1412(2)(B). Under the EHA-B regulations, at 34 CFR Sec. 300.13(b)(13), "related services" is defined to mean "transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education. . . ." The term "transportation" as defined under 34 CFR Sec. 300.13(b)(13) includes:

> (i) Travel to and from school and between schools,
> (ii) Travel in and around school buildings, and
> (iii) Specialized equipment (such as special or adapted buses, lifts and ramps), if required to provide special transportation for a handicapped child.

The standard for determining whether a wheelchair must be provided as a related service, as set out in the regulation, is whether it is "required to assist a handicapped child to benefit from special education." 34 CFR Sec. 300.13(a). In addition, related services includes transportation, which is defined to include travel in and around school buildings and can involve the provision of specialized equipment. 34 CFR 300.13(b)(13)(ii), (iii).

Under the regulatory standards cited above, the school district is not required to provide a wheelchair for personal use outside the school but may be required to provide a wheelchair for transportation purposes while the child is receiving special education. This requires an analysis of the facts in each individual case. A parent raising this issue may request a due process hearing or file a complaint with the State. However, the Office of Special Education Programs is not in a position to analyze the facts in each individual case.

I hope that the above information is of assistance. If this office can be of further service, please let me know.

G. Thomas Bellamy, Ph.D.
Director
Office of Special Education Programs

Inquiry by: David S. Tatel
Hogan & Hartson
Columbia Square
555 Thirteenth St., N.W.
Washington, D.C. 20004-1109

Digest of Inquiry
(March 10, 1989)

- Where state permits parents to choose among school districts, must district of parents' residence delegate responsibility for appropriate special education services to district where student receives services?

Digest of Response
(April 14, 1989)

OSERS Will Study SEA/LEA Obligations in "Freedom of Choice" States

OSERS will study ramifications of state measures allowing parents freedom to choose among school districts, including issue of whether home district may delegate responsibility for delivery of appropriate special education services to district where student receives services.

Text of Inquiry

We are writing to you on behalf of the Westside Community School District to ask the Department of Education's opinion regarding an important issue raised by "choice" legislation now being considered by the state of Nebraska. This issue, which relates to the ability of handicapped students to participate in a program giving parents and students expanded choices, has national implications since so many states are now considering similar legislation.

The "choice" legislation that the State of Nebraska currently is considering would offer parents in one school district an opportunity to send their children to public schools in another district. Consideration is being given to including a provision that would allow a special education student to transfer to a non-resident district and would require delegation to the non-resident district of the resident district's responsibility for ensuring that a special education student who transfers pursuant to the proposed legislation receives an appropriate education. This delegation would include, for example, the resident district delegating to the non-resident district responsibility for development of individual educational plans and for conducting evaluations.

Our client's concern is that while it is clear that under federal law special education students must be allowed the opportunity to transfer under any "choice" legislation, it is unclear whether the proposed delegation of responsibility would create a conflict between state law and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Secs. 701, *et seq.* ("Section 504") and Education of the Handicapped Act, 20 U.S.C. Secs. 1400, *et seq.* ("EHA"). The possible conflict arises because EHA requires that each local education agency must provide assurances that payments received by it under the federal special education program be used "for costs directly attributable to programs which provide that all children residing within the local education agency . . . who are handicapped" receive appropriate educational opportunities. 20 U.S.C. Sec. 1414(a)(1)(A). Similarly, Section 504 regulations provide that "[a] recipient shall provide a free appropriate public education to each qualified handicapped

Communication is an essential part of learning and of being a member of society, and it serves both educational and medical goals (see EHLR 353:286, OCR May 17, 1989).

* Speech and language services also are an important part of the FAPE provided to students who have learning disabilities that may impair their ability to receive and process information from traditional oral and written sources. As appropriate, equipment and/or devices that may aid these students may be included in the IEP, as well as the follow-up services needed to ensure the child can use the device as intended.

c. Audiology

* The EHA regulations define audiology services to include:

(i) identification of children with hearing loss;
(ii) determination of the range, nature and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing;
(iii) provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip reading) hearing evaluation, and speech conservation;
(v) counseling and guidance of pupils, parents, and teachers regarding hearing loss; and
(vi) determination of the child's need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.

* In addition, the EHA regulations contain a separate provision mandating that as part of a FAPE, schools ensure that hearing aids are functioning properly. The basis for the rule is a 1976 study that concluded up to one-third of the hearing aids then in use were malfunctioning (34 C.F.R. Section 300.303).

* These rules make clear that assistive technology devices or services needed by hearing impaired children can be a related service. These include hearing aids and other amplification devices, sign language interpreters, special teacher training, and teachers for the deaf.[27]

d. Physical & Occupational Therapy

* The EHA regulations define physical therapy in very general terms. It includes "services provided by a qualified physical therapist" (34 C.F.R. Section

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[27] One caveat: If a child with a hearing impairment is able to maintain a regular class placement and proceed from grade to grade with her age peers without a sign language interpreter, then one will not be required. The Supreme Court, in the Rowley decision stated that alternate teaching methods that are sensitive to the child's hearing impairment were sufficient: it is enough that the child can be in regular education. It is not required that the school "maximize" her educational potential.

Education had not been made aware of the delay by her staff. We find that neither of these reasons justifies the extensive delay in deciding the appeal in this case. Further, although the parents' attorney did not forward his memorandum in support of their appeal until some time in October, there is no requirement than an appeal officer delay his decision until one is filed or which provides that the timeline for disposition of an appeal be tolled until such a memorandum is received. There is no evidence that any portion of the delay was due to the appeal officer granting either party a specific extension of time for any reason including filing a supporting memorandum. Such an extension is the only method for extending the 30-day period for rendering a decision in the State Regulations. Even assuming that the appeal officer had specifically granted an extension for the parents' attorney to file the memorandum supporting their appeal until the end of October 1988, a period of 141 days elapsed between November 1, 1988 and March 22, 1989, the day the appeal decision was rendered, which was well in excess of the allotted time period.

Our investigation also established that during the last two school years, the WVDE has received a total of 8 appeal requests. Of that total, only two or 25 percent were decided within 30 days. Of the six appeals which were not decided within 30 days, two were decided within 45 days, three were decided within 60 days and one, the instant case, took 217 days to decide.

The WVDE acknowledges that there is no procedure in place at the present time to ensure that the 30-day timeline in the State Regulations is met. Thus, we conclude that the WVDE violates Section 504 and its implementing regulation at 34 C.F.R. Section 104.36 by failing to render a timely appeal decision in the instant case thereby effectively denying the parents their procedural safeguards. In addition, the WVDE's failure to take action to ensure that timely decisions are rendered despite repeated instances of untimely reviews on appeal subjects qualified handicapped persons to discrimination and violates Section 504 and its implementing regulation at 34 C.F.R. Section 104.4(b)(4).

The WVDE has submitted assurances to OCR concerning actions it will take to ensure that decisions on appeals of local hearing decisions are rendered in a timely manner so as to satisfy the procedural safeguard requirements of the Section 504 regulation. Based on these assurances (copy enclosed), OCR finds the WVDE currently in compliance with the Section 504 and its implementing regulation at 34 C.F.R. Sections 104.4(b)(4) and 104.36 regarding the issues of this complaint. OCR will monitor implementation of these assurances. Failure to implement the measures as stated therein may provide the basis for a finding of noncompliance in the future.

This concludes OCR's investigation of this complaint, and we are closing our case file effective the date of this letter. This letter is not intended, and should not be construed, to cover any other issues regarding compliance with Section 504 which are not specifically discussed herein.

Please be advised that retaliation against persons who cooperate with or participate in an investigation is prohibited under the Section 504 regulation at 34 C.F.R. Section 104.61, which incorporates by references 34 C.F.R. Section 100.7(e) of the regulation implementing Title VI of the Civil Rights Act of 1964.

Under the Freedom of Information Act, it may be necessary to release this document and related correspondence and records upon request. In the event that OCR receives such a request, we will protect, to the extent provided by law, personal information which, if released, would constitute an unwarranted invasion of privacy.

This office is prepared to provide technical assistance in response to questions raised that may arise in the future regarding any of the regulations enforced by OCR. If at any time you or a member of your staff is interested in the technical assistance available through this office, please contact Mr. Robert Ford, Acting Chief, Regional Technical Assistance Staff at (215) 596-6098.

We wish to thank you and members of your staff for the cooperation and courtesy extended to the OCR staff member during the course of this investigation. If you have any questions, or if we can assist you in any way, please feel free to contact me or Mr. Theodore G. Nixon, Director, Elementary and Secondary Education Division, at (215) 596-6740.

Robert A. Smallwood
Regional Civil Rights Director
Region III

LOGAN COUNTY (WV) SCHOOL DISTRICT

May 17, 1989

Complainant alleged district discriminated against handicapped student with cerebral palsy by failing to evaluate and place him in an appropriate educational program and provide services based on his individual needs. Complainant contended that district, without conducting its own evaluation, refused to provide a communication device recommended by an evaluation team, and a full-time aide recommended by the student's physician. Complainant also alleged district failed to provide physical therapy until six months after the beginning of school, failed to implement the student's IEP by refusing to integrate him in music, P.E., and lunch, and failed to provide accessible cafeteria facilities.

***HELD:*, for the complainant on all issues.**

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District violated Sec. 504 and implementing regulations by its failure to follow proper evaluation and placement procedures to determine and provide for student's need for occupational and physical therapy, adaptive P.E., communication device, and full-time aide. OCR found that, despite repeated requests from the parents, district did not evaluate or determine placement for O.T. or adapative P.E. District also failed to evaluate for P.T. until six months after the beginning of 1987-88 school year. District failed to follow up on an evaluation and recommendation for a communication device for over a year and, at the time of OCR's visit the device was inoperable. Also, district failed to respond to parents' request and physician's recommendation for full-time aide for five months. This failure to provide timely evaluations and placements violated Reg. 104.35.

OCR concluded that district's failure to institute truancy proceedings during student's fifty-five-day absence from school denied him a free appropriate public education, in violation of Reg. 104.33.

District violated Reg. 104.34(a) and (b) when it failed to implement student's IEP, which provided for his integration in music, lunch, and P.E. Student had been excluded from music and P.E. due to administrative error. Student could not be integrated during lunch because of inaccessible cafeteria facilities. Non-handicapped students ate lunch on a stage, while handicapped students had food carried to them at the bottom of the stage because of physical barriers such as stairs and a doorway. This was a violation of Regs. 104.21, and 104.22(a) and (b).

Mr. Wesley Martin
Superintendent
Logan County School District
P.O. Box 474
671 East Stratton Street
Logan, West Virginia 25601

Complaint No. 03-89-1057

The Office for Civil Rights (OCR), U.S. Department of Education (the Department) has completed its investigation of the above referenced complaint which alleges that the Logan County School District (the District) discriminated on the basis of handicap. Specifically, the complainant, an advocate, alleges that the District discriminated against [ ] by its failure to: (1) provide an appropriate evaluation and placement; (2) provide educational services during the 1988-89 school year until November 1988; (3) implement the provisions of his individualized education program (IEP); (4) provide integration with nonhandicapped students for nonacademic subjects; (5) provide services based upon [ ] individual needs; and (6) provide readily accessible cafeteria services.

OCR is responsible for enforcing Section 504 of the Rehabilitation Act of 1973 (Section 504) and its implementing regulation, 34 C.F.R. Part 104, which prohibit discrimination on the basis of handicap in federally assisted programs and activities. The District is a recipient of Federal financial assistance from the Department and is, therefore, subject to Section 504 and its regulation as to the issues raised by this complaint.

Pursuant to OCR's enforcement responsibility, OCR conducted an investigation of this complaint. The investigation included a review of information submitted by the complainant and the District and interviews with District representatives, the complainant, and [ ] parents. Based on a thorough analysis of the evidence gathered, OCR concluded that the District violated Section 504 and the Department's implementing regulation by failing to: (a) implement proper evaluation and placement procedures; (b) place [ ] with nonhandicapped students to the maximum extent appropriate to his individual needs; (c) provide a free appropriate public education by not providing an educational program and related aids and services based upon his individual needs; and (d) provide readily accessible cafeteria services. However, we have concluded that the District complied with 34 C.F.R. Section 104.36 because it provided [ ] parents with notice of their procedural safeguards. The District has submitted assurances to OCR that correct the above mentioned violations. Consequently, the District is in compliance with Section 504 and the Department's implementing regulation with respect to the issues raised in this complaint. The bases for our findings and conclusions are summarized below.

The regulation implementing Section 504, at 34 C.F.R. Section 104.33(a), provides that a recipient operating a public elementary or secondary program must provide a free appropriate public education to each qualified handicapped person in its jurisdiction. The regulation, at 34 C.F.R. Section 104.33(b)(1), defines an "appropriate education" as the provision of regular or special education and related aids and services that are designed to meet the individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met and are based upon adherence to procedures that satisfy the requirements of Sections 104.34, 104.35 and 104.36. The regulation, at 34 C.F.R. Section 104.33(c)(1), further provides that the provision of a free appropriate public education is the provision of educational and related services without cost to the handicapped person or to his/her parents or guardian, except for those fees that are imposed on nonhandicapped persons or their parents or guardian. The interpretative comments to the Section 504 regulation state that it is not the intention of the Department except in extraordinary circumstances to review the results of individual placement and other educational decisions, so long as the school district complies with the "process" requirements of the regulation concerning identification and location, evaluation, and due process procedures. (See Section 504 regulation, Appendix A, Subpart D.)

The Section 504 regulation requires recipients to provide for the education of handicapped students with nonhandicapped students, to the maximum extent appropriate to the educational needs of the handicapped students. Thus, a recipient must place a handicapped person in the regular educational environment unless it is demonstrated by the recipient that such a placement cannot be achieved satisfactorily with the use of supplementary aids and services. 34 C.F.R. Section 104.34(a). The regulation, at 34 C.F.R. Section 104.34(b), also provides that in providing or arranging for the provision of nonacademic and extracurricular services and activities, a recipient must ensure that handicapped persons participate with nonhandicapped persons in such activities and services to the maximum extent appropriate to the needs of the handicapped person in question.

The Section 504 regulation also establishes procedures designed to ensure that children are not misclassified, unnecessarily labeled as handicapped, or incorrectly placed, based on inappropriate selection, administration, or interpretation of evaluation materials. The regulation, at 34 C.F.R. Section 104.35(a), requires that an individual evaluation be conducted before any action is taken with respect either to the initial or any subsequent significant change in placement of a child who, because of handicap, needs or is believed to need special education or related services. The regulation requires a recipient to establish standards and procedures for the evaluation and placement of handicapped students, 34 C.F.R. Section 104.35(b), and also requires a recipient to draw upon a variety of sources in the evaluation and placement process so that information from all sources is documented and considered by a group of persons knowledgeable about the child and the placement options. 34 C.F.R. Section 104.35(c).

The Section 504 regulation does not set forth a time limit for the completion of evaluation and placement procedures. However, unreasonable delays in evaluation and/or placement in special education constitute discrimination against handicapped students because they necessarily deny such children meaningful access to educational services provided to other children.

The Section 504 regulation requires recipients operating public elementary and secondary school programs to establish and implement a system of procedural safeguards regarding the identification, evaluation, or educational placement of persons who, because of handicap, need or are believed to need special instruction or related services. The system of procedural safeguards must include, at a minimum, notice, an opportunity for the parents or guardian of the person to examine relevant records, an impartial hearing with opportunity for participation by the person's parents or guardian and representation by counsel, and a review procedure. 34 C.F.R. Section 104.36

The regulation implementing Section 504, at 34 C.F.R. Section 104.21, provides that no qualified handicapped person shall, because a recipient's facilities are inaccessible to or unusable by handicapped persons, be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any program or activity to which this part applies. For "existing" facilities constructed prior to June 3, 1977, the Section 504 regulation requires recipients to ensure that each educational program or activity, when viewed in its entirety, is readily accessible to and usable by handicapped persons. The regulation does not require a recipient to make each of its existing facilities accessible to and usable by handicapped persons. 34 C.F.R. Section 104.22(a). The regulation, at 34 C.F.R. Section 104.22(b), provides that accessibility is not necessarily dependent upon structural alteration of existing facilities but may be accomplished, among other methods, by redesigning equipment, reassigning classes, assigning aides or constructing new facilities.

Background

[ ] is a [ ] year old student with cerebral palsy who uses a wheelchair. He currently attends [ ] Elementary School in a [ ] grade class. He is nonambulatory and requires assistance in toileting, feeding, dressing and personal hygiene. [ ] speech is unintelligible. His present means of communication consists of gestures, facial expressions, vocalizations, and use of a picture and sentence board. He was evaluated several times prior to becoming a student in the District. Upon his arrival at the District, [ ] initially was placed in a [ ] grade regular education class for the 1987-88 school year. However, the District, in accordance with its procedures, tested and identified [ ] as a person in need of special education in the fall of 1987. As part of its identification process, the District engaged the [ ] Center to conduct occupational therapy, physical therapy and nonvocal communication evaluations. In November 1987, the school psychologist conducted a psychological evaluation of him.

On November 23, 1987, the Director of the Developmental Therapy Center, Inc., transmitted the results of its evaluation to the District. Overall, these evaluations indicated the types of equipment [ ] required to achieve an appropriate education, and not the type of day-to-day educational services he needed. For example, the occupational and nonvocal communication evaluations showed that [ ] needed a communication device to give him the independence to indicate answers in class and to communicate with those unable to

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understand his verbal speech. Similarly, the occupational and speech therapists recommended that [ ] use a prone stander, a scooter and a mat.

On December 10, 1987, a Placement Advisory Committee (PAC) was convened. Based upon the evaluations, the PAC recommended continuation of [ ] regular education program with modifications, which included a full-time aide and use of a mat, and multiple choice tests. However, [ ] then underwent spinal surgery to have a device implanted to help control his spasticity on January 7, 1988 and was placed on homebound instruction for the remainder of the 1987-88 school year. Consequently, another PAC was convened on January 28, 1988 to determine [ ] homebound instruction for the remainder of the 1987-88 school year.

[ ] and his parents returned to the Developmental Therapy Center on March 9, 1988, to discuss [ ] nonvocal communication evaluation with two speech language pathologists, an occupational therapist and a representative from a vocal aid company. The evaluation team recommended a particular communication device and submitted this recommendation to the District. The District, however, did not conduct any additional evaluations or take any other action with respect to the identification and purchase of an appropriate communication device for the remainder of the 1987-88 school year.

In preparation for the 1988-89 academic year, a PAC met on June 8, 1988 to determine [ ] proposed educational placement. Using the evaluations from the 1987-88 school year, the PAC recommended a special education placement in a Mildly Mentally Impaired (MMI) class. In addition, the PAC, denying the parents' request, declined to provide a full-time aide to [ ]. The parents objected to this placement and refused to sign the Individualized Education Program (IEP). Because the parents refused to sign the IEP, school officials advised the parents that [ ] would remain in his current placement, i.e., a regular education classroom.

On July 18, 1988, prior to the commencement of the school year, [ ] surgeon wrote to the District and "strongly urged that an aide accompany [ ] during the school days to insure that [ ] system [that is, the device which was implanted to control his spasticity] is in no way tampered with." The District, without conducting its own evaluation, still declined to provide a full-time aide. Because the District recommended MMI placement and refused to provide [ ] with a full-time aide, his parents did not return him to school until November 28, 1988.

Prior to [ ] return to school on November 28, 1988, two PACs met. On October 19, 1988, a PAC meeting ended abruptly when the District refused the parents' request for a single person (aide) to work directly with [ ] throughout the 1988-89 school year. Another PAC met on November 21, 1988, with the parents and complainant in attendance. The PAC developed in IEP with educational goals and objectives but the parents refused to sign it because there were no goals and objectives for occupational therapy, physical therapy, adaptive physical education and nonvocal communication. In addition, no agreement was reached on a communication device, and the District refused the parent's request for an independent, nonvocal communication evaluation in Baltimore, Maryland. Despite their refusal to sign the IEP, [ ] parents returned him to school on November 28, 1988.

On November 29, 2988, the parents presented the District with a doctor's note indicating that [ ] should receive physical therapy five times a week. The District, however, did not conduct its own physical therapy evaluation until February 14, 1989. The District's physician recommended biweekly physical therapy and subsequently, during the week of February 20, 1989, [ ] began biweekly physical therapy.

Although the [ ] Center assessed [ ] for a nonvocal speech device in November 1987, the District did not conduct a follow-up evaluation until November 29, 1988, when the Assistant Director of Special Education and the School Psychologist visited the Center. Based upon the Center's recommendation, the District purchased a communication device on February 7, 1989. However, the communication device requires modifications to meet [ ] needs and at the time of OCR's onsite investigation was still inoperable. Furthermore, the District, to date, has failed to conduct occupational therapy and adaptive physical education evaluations for the 1988-89 school year.

Discussion

A. Identification, Evaluation and Placement

OCR found that the District failed to take appropriate steps to identify and evaluate [ ] to determine his needs for special education and related aids and services for the 1988-89 school year. Specifically, the District did not follow proper evaluation and placement procedures with respect to [ ] needs for occupational therapy, physical therapy, adaptive physical education, nonvocal communication and aide services. For example, the District has failed to evaluate or determine a placement for [ ] for occupational therapy or adaptive physical education for the 1988-89 school year. In addition, the District did not evaluate [ ] for physical therapy, or begin such services, until February 1989, six months into the school year. Although the District contracted with the [ ] Center to conduct a nonvocal communication evaluation in November 1987, OCR found that it was not until November 29, 1988, a year later, that District officials began to follow up on the Center's evaluation and recommendation. Based upon the Center's recommendation, the District purchased a communication device on February 7, 1989. The communication device, however, needs modifications and is currently inoperable. Finally, the District did not evaluate and determine [ ] need for an aide until

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November 1988. Although [ ] parents requested a full-time aide in June 1988, and his surgeon wrote to the District in July 1988 recommending a full-time aide, OCR found no evidence to suggest that the District conducted its own evaluation until November 1988, when the special education nurse examined [ ] and determined that he, indeed, needed a full-time aide. In the meantime, the District continued to develop and offer proposed educational placements for [ ] despite the lack of complete evaluations in several critical areas. Accordingly, we conclude that the District did not follow proper evaluation and placement procedures and therefore, violated the Section 504 regulation at 34 C.F.R. Section 104.35.

B. Least Restrictive Environment

OCR found that the District is not educating [ ] with nonhandicapped students to the maximum extent appropriate to his needs. [ ] IEP specifies that he should attend lunch, music and physical education with nonhandicapped students. Our investigation established that [ ] eats lunch and attends music class and physical education only with other handicapped students. District officials admitted that [ ] did not attend music and physical education with nonhandicapped children due to administrative error and was isolated during lunch because the regular lunch time seating was inaccessible. (*See* Section E—Program Accessibility) We, therefore, conclude that the District is not educating [ ] with nonhandicapped students to the maximum extent appropriate to his individual needs as required by 34 C.F.R. Section 104.34(a) and (b).

C. Free Appropriate Public Education

OCR found that the District is not providing [ ] free appropriate public education because it has failed: (1) to take steps to secure [ ] school attendance; (2) to determine and provide an educational program and related aids and services to [ ] based upon his individual needs; and (3) to implement the provisions contained in [ ] IEP.

Because [ ] parents disagreed with his placement for the 1988-89 school year, they refused to return him to school until November 28, 1988. During his absence from school, however, the District did not contact truancy officials as required by its own truancy policy or initiate due process proceedings in an effort to have the student return to school. In total, [ ] was absent for approximately fifty-five school days. The District's failure to attempt to secure [ ] attendance in school during this time period had the effect of denying him a free appropriate public education.

As previously discussed, the District failed to implement appropriate procedures for identifying, evaluating and placing [ ] in an appropriate educational program with related aids and services based upon his individual needs. (*See* Section A—Identification, Evaluation and Placement). This failure to implement proper identification, evaluation and placement procedures had the effect of denying [ ] a free appropriate education.

The District also failed to implement particular provisions of [ ] IEP. Despite the explicit mandate of the IEP, the District admittedly has not integrated [ ] with nonhandicapped students for lunch, music and physical education. (*See* Section B—Least Restrictive Environment) This failure to implement the student's IEP deprived him of a free appropriate public education.

We, therefore, conclude that the District failed to provide an appropriate education program to [ ] because it did not adhere to procedures that satisfy the requirement of 34 C.F.R. Sections 104.34, 104.35 and 104.36 in each of the areas discussed above. Thus, the District has failed to comply with the requirements of 34 C.F.R. Sections 104.33(a) and (b)(1).

D. Procedural Safeguards

OCR found that the District complies with its obligation to provide procedural safeguards to parents. Specifically, the District provides notice to a parent and/or guardian prior to conducting any assessment and/or evaluation, in accordance with its established written procedures. In addition, the District notifies parents of placement advisory committee meetings and affords parents the opportunity to participate in such meetings. The District also provides parents with notice of annual reviews. A copy of the District's procedural safeguards notice, Form DP-14, accompanies each notification to the parent or guardian. This notice informs parents or guardians that they have, among other things, the right to (1) inspect and review all relevant records, (2) meet with school personnel to discuss the referral and evaluation procedures, (3) give or withhold consent to the evaluation, (4) object to the evaluation and request a hearing, and (5) request extended school year programming for their children during the summer months if their children are severely handicapped, lose skills previously learned or have great difficulty relearning skills.

In the instant case, the District conducted a PAC meeting which the parents attended on October 9, 1987. The PAC discussed the evaluations including psychological, speech/language, physical and occupational that were to be conducted and incorporated the evaluations into the IEP. The parents signed the IEP authorizing the District to implement the provisions of the IEP. On the first page of the IEP where the parent/guardian signature appears, it states, "I have had my rights presented to me and I understand these rights...." The District also provided the parents with notice of extended

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school year programming. In addition, the District provided notice and procedural safeguards (Form DP-14) to the parents for the PAC meetings held on June 8, 1988, October 19, 1988 and November 21, 1988. Therefore, we conclude that the District has complied with the procedural safeguard requirements of 34 C.F.R. Section 104.36

E. Program Accessibility

The complainant alleges that cafeteria services are not readily accessible to [ ]. Although OCR relied upon the accessibility requirements of the Section 504 regulation at 34 C.F.R. 104.22, OCR used the American National Standards Institute's (ANSI) specifications and the Uniform Federal Accessibility Standards (USAF) for the removal of barriers for children as guidelines.

The [ ] Elementary School was constructed in 1960 and since then no modifications/renovations have been made to the cafeteria. The cafeteria and stage are located at one end of the gymnasium and have separate doorways. Nonhandicapped students eat lunch on the stage while [ ] and his handicapped classmates eat lunch at the bottom of the stage since the stage itself is not accessible to mobility-impaired persons. The areas that are accessible to mobility-impaired persons include the gymnasium and doorways to the gymnasium. The barriers to accessibility for mobility-impaired persons include the steps to the cafeteria and stage, the doorway to the cafeteria and the cafeteria's tables, chairs, and service line.

The applicable regulation at 34 C.F.R. Section 104.22(b), does not require that each part of an elementary school which is classified as an "existing facility," be made accessible or that all facilities, equipment and furniture be made usable by handicapped persons. Rather, the regulation requires that a recipient make accessible a sufficient number of areas, facilities, furniture and equipment so that handicapped persons can participate in each of the programs operated by the recipient. In addition, it is not always necessary to implement structural changes to make a program accessible. In many instances, other equally effective methods may be used. For example, a recipient does not always need to make its cafeteria accessible to handicapped persons if equivalent food services are made available to handicapped persons at an alternative, accessible location so long as priority is given to the most integrated setting appropriate.

Because of his mobility impairment, [ ] cannot get to the food service area or the stage area seating. Also, because of his spasticity, [ ] is unable to obtain his own lunch through the service line. Consequently, [ ] as well as some of his special education classmates, have had their lunchtime seating relocated to the area in front of the stage, and [ ] lunch is brought to him by another student under the supervision of the teacher. Under these circumstances, we conclude that the method chosen by the District of making the program accessible (i.e., food services in a segregated location) does not comply with the requirements of 34 C.F.R. Sections 104.21 and 104.22(a). In light of [ ] inability to use the food service line independently, we find that another person carrying his meals to him is an adequate aid. However, because the District has relocated [ ] eating area to a location used only by handicapped persons, and no adequate justification for this isolation has been asserted by the District, we find that the District has failed to select a method of achieving program accessibility which provides for integration with nonhandicapped persons.

We therefore conclude that the District has failed to provide readily accessible cafeteria services. Thus, the District has failed to comply with the requirements of 34 C.F.R. Sections 104.21 and 104.22(a) and (b).

In summary, with respect to [ ] during the 1988-89 school year, the evidence demonstrates that the District violated Section 504 and the Department's implementing regulation at 34 C.F. R. Sections 104.21, 104.22(a) and (b), 104.33 and 104.34(a) and (b) by failing to: (1) implement proper evaluation and placement procedures; (2) place [ ] with nonhandicapped students to the maximum extent appropriate to his individualized needs; (3) provide a free appropriate public education by not providing an educational program and related aids and services based upon [ ] individual needs; and (4) provide readily accessible cafeteria services. However, we have concluded that the District complied with 34 C.F.R. Section 104.36 because [ ] parents received notices of their procedural safeguards. The District has submitted assurances to OCR (copy enclosed) that correct the violations identified above.

Based on the assurances that the District will implement the remedial action set forth in the enclosed document, OCR considers the District to be fulfilling its obligations under Section 504 and its implementing regulation with respect to the issues of this complaint. Thus, OCR is closing this case effective the date of this letter. Continued compliance, however, is contingent upon the implementation of the enclosed assurances. Failure to fulfill the assurances may result in a finding of violation. As in our standard practice, compliance with commitments and assurances will be monitored by OCR.

This letter of finding only addresses the issues listed above and, therefore, should not be interpreted as a determination of compliance or noncompliance with Section 504 regarding other issues that may exist and are not discussed herein. Please be advised that retaliation against persons who cooperated with or participated in the investigation is prohibited under the Section 504 regulation at 34 C.F.R. Section 104.61, which incorporates by reference 34 C.F.R. Section 100.7(e) of the regulation implementing Title VI of the Civil Rights Act of 1964. Under the Freedom of Information Act, it may be necessary to release this document and related correspondence and records upon request. In the event OCR receives such a request, we will protect, to the extent provided by law, personal information which, if released, would constitute an unwarranted invasion of privacy.

OCR is prepared to provide technical assistance in response to questions which may arise in the future regarding any of the regulations enforced by OCR. If at any time you or a member of your staff is interested in technical assistance available through this office, please contact Mr. Robert Ford, Acting Chief, Regional Technical Assistance Staff at (215) 596-6098.

We wish to thank you and the members of your staff for the cooperation and courtesy extended to OCR staff during the course of this investigation. We are particularly grateful to Mr. Randolph Gilbert, Director of Special Education, for coordinating our onsite visit and responding to our requests for information. If you have any questions, please contact me or Mr. Theodore G. Nixon, Director, Elementary and Secondary Education Division, at (215) 596-6740.

CURWENSVILLE AREA (PA) SCHOOL DISTRICT

May 24, 1989

Complainant alleged district discriminated against student by disciplining him for actions resulting from the student's alleged handicap, which included skipping class, being disruptive, and being unprepared in class. In addition, complainant contended that District denied all handicapped students a free appropriate public education by failing to provide timely evaluations and to notify parents of procedural safeguards.

HELD: for the parent on issues of appropriate referrals, notice of procedural safeguards, and review and maintenance of educational records.

District was in compliance on issues of improper disciplinary action and failure to provide timely evaluations. District was in violation of Section 504 and implementing regulations because it systematically failed to inform parents of procedural safeguards during the pre-referral process, waiting instead until a formal referral for evaluation had been made. Parents were provided a written notice of their rights only after a child study team determined that an evaluation was warranted. In addition, OCR found that the district had failed to implement procedures to ensure that students were referred for assessment to determine whether they needed comprehensive evaluations as soon as the students were suspected of needing special education or related services. Many teachers were not aware that students must be referred as soon as the need for specialized education is suspected. Some teachers tried pre-referral interventions for an entire grading period before making a referral for evaluation. During the on-site visit, OCR also found that student records were kept in various locations, so that no student's complete file was in one designated place. This practice effectively denied parents an opportunity to review their child's education records.

Dr. Robert Dreibelbis
Superintendent
Curwensville Area School District
650 Beech Street
Curwensville, Pennsylvania 16833

Complaint No. 03-89-1063

The Office for Civil Rights (OCR) of the U. S. Department of Education (the Department) has completed its investigation of the above referenced complaint which alleges that the Curwensville Area School District (the District) discriminated on the basis of handicap. Specifically, the complainant, an advocate for [ ] alleges that the District discriminated against [ ] by disciplining him for actions that resulted from his alleged handicap. In addition, the complainant alleges that the District denies all of its handicapped students a free appropriate public education by failing to provide timely evaluations and to notify parents of their procedural safeguards.

OCR is responsible for enforcing Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, 34 C.F.R. Part 104, which prohibit discrimination on the basis of handicap in federally assisted programs and activities. The District is a recipient of Federal financial assistance from the Department and is, therefore, subject to Section 504 and its regulation as to the issues raised by this complaint.

Pursuant to OCR's enforcement responsibility, OCR conducted an investigation of this complaint. The investigation included a review of information submitted by the complainant, the District, and the Central Intermediate Unit #10 (the IU) as well as interviews with District and IU personnel, the complainant, and [ ] mother. Based on a thorough analysis of evidence gathered, OCR concludes that, with respect to the individual allegation, the District did not discipline

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300.13(b)(7)).

- Occupational therapy is defined in functional terms:

(i) improving, developing or restoring functions, impaired or lost through illness, injury or deprivation;
(ii) improving ability to perform tasks for independent functioning when functions are impaired or lost; and
(iii) preventing, through early intervention, initial or further impairment or loss of function.

- In addition, the EHA regulations define the physical education component of special education to include motor development and movement education (34 C.F.R. Section 300.14(b)(2)(i)). Thus, occupational and physical therapy may be needed to assist the child to benefit from special education to the extent the child will require instruction to promote motor development or improvement movement.

- Both of these services will permit a full range of assistive technology devices and services to be incorporated into a child's IEP. Physical therapy services include evaluations and recommendations with regard to seating, positioning, and mobility devices. If they are needed for the child to benefit from special education, then they can be added to the IEP as a related service. The "improving, developing or restoring" to be accomplished through occupational therapy offers the same freedom. Any device or equipment that would aid the child in notetaking, physical education, eating, toileting can be included on the child's IEP and secured by the schools.

- Schools cannot evade their responsibilities to provide these services by claiming they are for "medical" and not "educational" purposes, or that they are for non-academic purposes. Not only is it an impossibility as a matter of fact to credibly distinguish a medical from an educational purpose for these services, the Office of Special Education Programs has concluded that these services are EHA related services even if they serve both a therapeutic and educational purpose (OSEP Mem. 87-21; June 29, 1987, reprinted in _EHLR_ 202:372-374). The Office of the Assistant Secretary for Special Education & Rehabilitation Services also has concluded that a service that serves a non-academic goal still can be an EHA related service (_EHLR_ 213:118, OSERS March 25, 1988).

e. "School Health Services"

- The EHA regulations define school health services to include services provided by a qualified school nurse or other qualified person (34 C.F.R. Section 300.13(b)(10)).

- School districts have had different reactions to children with special health care needs. Some have accepted them and served their needs without fanfare or complaint. Others react by attempting to exclude these children from school. However, schools should

OSEP MEMORANDUM 87-19

June 4, 1987

Contact Person: Thomas B. Irvin
Telephone: (202) 732-1007

TO: Chief State School Officers

FROM: G. Thomas Bellamy, Ph.D.
Director
Office of Special Education Programs

SUBJECT: Part H Funding Formula for the Insular Areas

Under Part H of the Education of the Handicapped Act Amendments of 1986 (P.L. 99-457), the U.S. Department of Education has discretion to reserve one percent of the funds appropriated for Part H in any fiscal year for allocation to the insular areas.

Several of the insular areas have asked us to make the full one percent available this year. The insular areas eligible for funding under Part H are Guam, American Samoa, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, and the Republic of Palau.

After considering the level of need and the increased focus on special education services in the insular areas in recent years, we have decided to exercise that discretion and reserve one percent of the Part H appropriation for allocation to the insular areas.

We are pleased to announce this funding decision.

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OSEP MEMORANDUM 87-21

June 29, 1987

Contact Person: Jeffrey F. Champagne
Telephone: (202) 732-1056

TO: State Directors of Special Education

FROM: G. Thomas Bellamy, Ph.D.
Director
Office of Special Education Programs

SUBJECT: Questions from State Directors on Part B of the Education of the Handicapped Act

In connection with recent meetings with State Directors of Special Education, the Office of Special Education Programs has solicited questions of interest to the State Directors. Some of these questions either were not addressed during the meetings or warranted answers that were reiterated in writing for broader use. In order to facilitate the effective implementation of EHA-B and to be responsive to questions raised, several of the questions are discussed in this memorandum.

The first two questions relate to the development of EHA-B policies and procedures; the third and fourth questions concern OSEP's implementation of recent statutory changes; and the remaining questions cover a variety of separate issues.

It is OSEP's hope that this will be the first in a series of periodic memoranda addressing issues of interest raised outside of the context of specific cases.

1. *Question:* When OSEP talks about State plan policies and procedures, what does OSEP mean by "procedures"? What is an "operational" policy or procedure?

Answer: Generally, policies are statements of *what* is to be achieved and procedures are statements of *how* to achieve it. More specifically, procedures are the written statement of the steps that an agency will take (or require others to take) to ensure that the agency's policies are understood and carried out. Proper policies and procedures include a clear description of the actions to be taken, the person(s) responsible for taking the actions, and the timelines for completing the action.

In general, "operational" means "ready to use" or capable of implementation without a need for further explanation. For our purposes, it refers to policies and procedures that are stated in a way that ensures that everyone involved knows what is expected of them and what is expected of the system. The attributes of an "operational" set of policies and

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procedures include: a clear definition of the circumstances at require that action be taken; specificity and clarity of the ons to be taken and the persons and timelines involved; comprehensiveness in the articulation of the issues and actions to be taken in account; statement of the steps in behavioral terms, so that the persons with responsibility will literally know what to *do;* a means of measuring whether the tasks have been done consistent with the intent of the policy; and a means of tracking and a way of actually measuring performance.

The ultimate goals of a set of procedures are to ensure that desired outcomes are achieved and improper outcomes are avoided. Stating policies and procedures in operational terms is a good way to do this.

2. *Question:* How does an SEA write procedures in a decentralized State?

Answer: This is an important question because — given the many requirements of EHA-B and the fact that EHA-B is a State administered program — States must play an active role in implementing the statute at the State and local level. This includes the responsibility of an SEA to set standards and ensure local compliance. Some decentralization, however, can be accommodated. If a State does not wish to specify the details of all steps to be taken by relevant agencies to achieve State objectives, it can carry out its responsibilities through: (1) clear statements of policy as described above; (2) ecification of the range of discretion it is giving the LEAs, ected outcomes, and sample methods; combined with (3) thorough LEA applications procedures and monitoring. The thorough application and monitoring procedures should be designed to ensure that, while the SEA has given the LEAs a range of possible ways of implementing State policies, the LEAs have in fact stayed within that range.

3. *Question:* How are the EHA Amendments of 1986 (P.L. 99-457) going to affect State plan requirements under EHA-B? What do you mean when you say that OSEP will be "funding under the statute" this year?

Answer: The statement that OSEP is "funding under the statute" means that OSEP is using the standards contained in the statute, rather than the standards in any proposed or predicted regulations covering the 1986 Amendments. For States, this means that, to the extent that a State plan obligation clearly exists in the recent statute, the obligation must be fulfilled through a State plan amendment in order to receive further EHA-B funding. Further definitions, guidance, or explanations that might appear in future regulations, however, need not be reflected in State plans during 1987.

OSEP memorandum 87-3 discusses the impact of the 1986 Amendments on State EHA-B plans in more detail. That memorandum discusses each section of the 1986 endments that amends Part B plan requirements, and ribes how to amend State plans to ensure funding in 1987. The long-term impact will be articulated in a Notice of Proposed Rulemaking (for public comment) and a final rule amending 34 C.F.R. Part 300.

4. *Question:* What will happen if new regulations are finalized in the middle of the year?

Answer: After receiving public comment and making any appropriate changes, OSEP will publish final regulations reflecting the 1986 Amendments. EHA-B grants made prior to the publication of final regulations are governed by the terms of the statute, the pre-existing regulations, and OSEP memorandum 87-3, rather than by any additional terms that might be included in new regulations. The new regulations will not be binding on a State until it receives a grant at some point after the publication of the new regulation. This will be true also for the preschool (Section 619) program and infants and toddlers (Part H) program. This means that, if a State were to receive a grant prior to the publication of a final regulation but then elect not to seek additional grant funds after the final regulations are published, the new regulations would not apply to the earlier grant even if the State is spending grant money after the final regulation is published.

Mid-year State plan amendments will not be required. If the regulations require elements that are not already in a State's plan, the State plan would have to conform to the regulation as of the time that the State wished to receive a grant for a subsequent year. For example, if 34 C.F.R. Part 300 is amended in October 1987, State plans would have to be amended prior to receiving a July 1988 EHA-B grant, but mid-year amendments would not be necessary.

We expect that the regulations will not significantly add to the requirements of the statute and OSEP memorandum 87-3. We therefore anticipate that States conforming this year to the statute and to OSEP memorandum 87-3 will not have to make significant State EHA-B plan changes in order to receive a post-regulation EHA-B grant.

5. *Question:* Will corrective action plans for States monitored by OSEP have to be approved to get State plan approval?

Answer: The general topic of the relationship between monitoring reports and State plan approval was discussed in OSEP memorandum 87-5. In response to this specific question, we add that, if the corrective action plans are not yet due when OSEP is otherwise ready to make a grant, the absence of a corrective action plan will not hold up the flow of funds. States must, however, stay on an agreed upon schedule for the planning and implementation of corrective actions in order to get final plan approval and continued Federal payments.

6. *Question:* How can SEAs handle private school placements when the placement is based on non-educational reasons?

Answer: This question covers many possible factual situations. Two of them are addressed here.

If a placement is made for a non-educational reason that is valid and there is no ability for the LEA to offer an alternative, the responsibility of the SEA and LEA is basically to provide FAPE wherever the child is placed. The typical example would be a child in a correctional facility or a hospital. Placements that are truly beyond the power of an educational agency will not be "held against" the educational agency when compliance with the "least restrictive environment" provisions is assessed; such placements are just "facts" with which the educators must work as they ensure that FAPE is provided to the child.

Another type of situation is one in which the parent places the child for non-educational reasons such as proximity to medical care of the parent's choice. If the parent then seeks tuition payment from an LEA, the LEA should apply its usual placement procedures. If the LEA makes or would have made the same placement decision under the EHA-B regulations that the parent made for other reasons, the LEA must provide FAPE as described in Regs. 300.400-300.402. If the LEA makes or would have made a different placement decision, the LEA's responsibilities are considerably less, as described in Regs. 300.450-300.452. In either case, the question turns on whether the LEA could have provided FAPE in a public school, not on whether the parent's choice was considered "educational" or "non-educational."

7. *Question:* What are the issues and requirements related to suspension and expulsion?

Answer: This is a complex area in which we are currently better able to articulate the issues than the answers. It is also relevant that the Supreme Court has decided to hear a case involving suspension and expulsion. Supreme Court review was requested by Superintendent Honig of California, and will take place some time after October 1, 1987.

OSEP's position is that a suspension or expulsion of more than ten days' duration constitutes a change in placement which would trigger the procedures and protections of EHA-B. This would include the "notice to parents" requirements in Reg. 300.504. OSEP has not developed a policy on when a series of shorter suspensions would accumulate to constitute a change in placement. We encourage SEAs and LEAs to be alert to the possibility that repeated discipline problems may indicate that the services being provided to a particular child should be reviewed or changed; we have not, however, established a specific rule or guidance on how many nonconsecutive days of suspension constitute a change in placement under EHA-B.

The formal comment to Reg. 300.514 says that, while a child's placement cannot be changed during the pendency of any administrative or judicial proceeding regarding a placement, "this does not preclude the agency from using its normal procedures for dealing with children who are endangering themselves or others." This would allow, for example, an LEA placement team to change the placement of an endangering student without waiting for the resolution, in administrative or judicial proceedings, of the dispute over the appropriateness of the new placement under EHA-B. (The applicability of the "pendency" provision is one of the two issues to be heard by the Supreme Court; the other issue is the nature of the SEA's responsibility when an LEA appears not to be serving a handicapped child appropriately.)

Some courts looking at the discipline issue under both EHA-B and Section 504 have said that, when the misbehavior is unrelated to the handicapping condition, the child can be disciplined without regard to the fact that the child has a handicap. This is of interest because the basis for this under EHA-B is not entirely clear. While this may deserve further thought, OSEP will not apply a rule or guideline contrary to this in the absence of a generally applicable statement distributed in advance to the States.

8. *Question:* What services come under related services? If a student is not receiving special education services but clearly needs related services such as occupational therapy (OT) or physical therapy (PT), how do you develop a policy and procedure to provide related services?

Answer: The ability to give OT and PT in the absence of any other special education services while counting the child as an EHA-B child depends on State standards. While OT or PT clearly fit within the definition of "related services" in 34 C.F.R. 300.13, they can also be part of "special education" — and thus be the only special education services provided where this is what is indicated in the assessment of the child. This is because the definition of "special education" at 34 C.F.R. 300.14(a)(2):

> includes speech pathology, or any other related service, if the service *consists of specially designed instruction*, at no cost to the parents, to meet the unique needs of a handicapped child, and is considered "special education" rather than a "related service" under State standards. (emphasis added)

Thus, the first step is to ascertain whether the issue is addressed in the standards or policies of the State. These standards or policies can include OT or PT as special education to the extent that the therapeutic services are also instructional services with educational content; that is, they must provide instruction directly aimed at reaching educational goals in order to be considered special education under State standards.

9. *Question:* Is teaching English as a second language (TESL) a related service if the child has been identified as handicapped and identified as being limited English proficient?

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complaint with the SEA on September 16, 1987, stating that the Special Education Director would not discuss the need for [illegible]ded school year services for your client's child.

[illegible] investigation of your complaint was conducted by the SEA. The SEA determined that (1) the IEP developed for the child at the meeting you discussed was a four-month interim IEP written so that appropriate evaluations could be conducted along with the provision of services to determine the child's need for an extended school year program, and (2) the only dispute with the four-month IEP was the duration of services (*see* 34 CFR Part 300, Appendix C, Question and Answer 5). The SEA directed the Special Education Director to inform the child's parents of the availability of mediation and due process procedures to resolve the dispute.

The Education Department General Administrative Regulations (EDGAR), 34 CFR 76.781(c), under which you appealed the SEA's decision, provide for an opportunity for complainants to request discretionary review of state agency decisions to the secretary. Therefore, the secretary has the authority to grant or deny the request for review. Section 207 of the Department of Education Organization Act delegates to me the responsibility for administering Part B of the Education of the Handicapped Act (EHA-B). This includes the responsibility for issuing decisions in appeals involving the EHA-B filed under the EDGAR provision for secretarial review.

We believe that your complaint revolves around essen-ially factual issues concerning the interim IEP developed for [illegible] in this case. Generally, requests for secretarial [illegible]e granted only when the case presents an issue of egal interpretation rather than a factual issue. The decision in his case to delay the determination of whether this child ieeded extended school year services for the period covered y the interim IEP does not indicate a systemic problem with espect to the extended school year issue in the state of Rhode sland. Therefore, pursuant to the above authority, a decision as been made to deny your request.

Thank you for bringing this matter to our attention.

Madeleine Will
Assistant Secretary
Office of Special Education
and Rehabilitative Services

Inquiry by: Mary Jo Butler
CO-AD, Inc.
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Boise, ID 83702

Digest of Inquiry
(November 16, 1987)

- May a school district limit the physical and occupational therapy provided a cerebral palsy student on the basis that the need is medical rather than educational?
- Must prevocational or other skills needed in the future be addressed in annual goals in the IEP?
- Is a physical therapist or occupational therapist a necessary participant at the IEP meeting?

Digest of Response
(March 25, 1988)

Therapeutic Services Required by EHA

Both occupational and physical therapy are related services that may be required to assist a handicapped child to benefit from special education; neither is defined in EHA or its regulations as a medical service.

Time Period for Annual Goals

Annual goals include those goals reasonably expected to be completed in a twelve-month period; in order to attain certain skills in the future, annual goals may include achievement of prerequisite skills.

Related Service Personnel Not Required at IEP Meeting

While it is appropriate for related services personnel to attend the IEP meeting of a child with an identified need for related services, EHA does not require their presence, and their participation may be in the form of written recommendations.

Text of Inquiry

As you are aware, recent cases and opinions concerning special education have attempted to make distinctions between educational and medical services and have attempted to define the school's responsibility for the provision of related services that are necessary for the student to benefit from special education. In Northern Idaho, this controversy has centered around the provision of physical therapy and occupational therapy as related services. As a staff attorney for the Idaho Protection and Advocacy agency, I am seeking clarification of these concerns on behalf of a client so that we may have clearer guidelines to distinguish between both "educational" versus "medical" related services and academic versus nonacademic "special education."

My client is an eight-year-old girl diagnosed as having cerebral palsy with right spastic hemiparesis. She has limited

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→ These letters have been edited to eliminate extraneous and irrelevant material.

use of her right hand and arm and, although ambulatory, has difficulty with gait and other gross motor skills. I have enclosed copies of her recent evaluations by physical and occupational therapists and her suggested physical therapy goals as developed by a physical therapist.

The school district personnel rejected all the suggested physical therapy goals except for those under upper body fine motor skills. The additional goals were rejected on the basis that only the accepted goals related to academic needs. They contended the other goals were medical and/or nonacademic and, therefore, not their responsibility.

34 C.F.R. 300.14 defines "Special Education" to mean "specially designed instruction . . . to meet the unique needs of a handicapped child. . . ." The term includes classroom instruction, physical education and vocational education. Related services are those necessary for her to benefit from any type of special education. "Instruction" for handicapped students can include instruction in many areas outside the traditional realm of academics. Often this includes instruction in perceptual motor skills, auditory discrimination training, self-help skills, independent living skills and prevocational skills, to name but a few areas. (See guideline Nos. 12, 36, 47, 50, 34 C.F.R. Part 300, Appendix C.)

I would hope that you could provide clarification in this area by addressing the following concerns:

1. Recognizing that most physical therapy and occupational therapy goals could be considered both medical and educational, what criteria can be used to distinguish the terms and at what point can the school district limit their obligation to provide recommended therapy?

2. If upper and lower body gross and fine motor skills are needed for a student to benefit from physical education, can the recommended goals be rejected either because they are not related to "academic" instruction or because a student has the ability to walk to the physical education class and be present in the classroom?

[NOTE: My client participates in a regular physical education class. Guideline 49(a) of Appendix C states that physical education can be mainstream placement with modifications as stated on the IEP and 34 C.F.R. 300.14(b)(2) defines physical education as the development of physical and motor fitness and fundamental motor skills and patterns, school district personnel have argued that because the student can walk to the gymnasium and participate at a reduced level of expectation, then they are not required to formulate IEP goals for increased motor skills. The client does participate in the class but at a very limited level in comparison with other students. For example, she holds on to one monkey bar while all the other students cross them several times.]

3. If a student needs increased upper and lower body gross and fine motor skills to benefit from prevoc tional instruction and vocational instruction whi will be offered in the future, is the school district required to include these goals on the IEP?

4. If a student needs increased upper and lower body gross and fine motor skills to increase her overall stamina and alertness and/or to enable her to participate as much as possible in school activities and programs, is the school district required to include these goals on the IEP?

5. May the school district personnel reject goals that are related to upper and lower body gross motor skills because they are not related to "academic" instruction in the same way as upper body fine motor skills are related to "academic" areas such as cutting, pasting and writing?

[NOTE: School district personnel have argued that because the student is ambulatory enough to move from class to class, the only physical therapy or occupational therapy goals they are required to consider are those relating to the fine motor upper body skills.]

6. If a parent requests the presence of a physical therapist or occupational therapist at a Child Study Team meeting to determine which of the recommended goals are acceptable under the "academic" or "me ical" standards, is the physical therapist a necessa participant as required by 34 C.F.R. 300.344?

7. If the school district denies reimbursement to the physical therapist or occupational therapist for his/her participation at the Child Study Team meeting or for developing recommended goals, is this effectively denying the parents their right to a FAPE or to having the necessary personnel develop the IEP?

I would appreciate a response from your department as soon as possible. As you are aware, the physical therapy needs of students must be addressed as soon as possible and become more difficult to remediate as time passes.

Text of Response

This is in response to your recent letter concerning the obligations of school districts in Idaho to provide services to children with handicaps under Part B of the Education of the Handicapped Act, as amended (EHA-B). While your letter raises concerns regarding the content of a child's individualized education program (IEP), which are most appropriate for resolution at an EHA-B due process hearing, this letter will provide general interpretive guidance in response to your specific inquiries.

The first concern raised in your letter is the extent of t' obligation of school districts in Idaho to provide physi therapy and occupational therapy to children with handicaps. [illegible]g to your letter, these school districts have objected [illegible] provision of such therapeutic services to children with handicaps because they characterize the children's needs for the services as "medical" rather than "educational." We find no support for this position in either the EHA-B statute or regulations.

School districts receiving EHA-B funds must ensure that children with handicaps "have available a free appropriate public education, which includes special education and related services to meet their unique needs." 34 C.F.R. 300.1(a) and 300.4; *see* 34 C.F.R. 300.2(b)(3) and 300.600(a)(2)(i). The term "related services" is defined as "such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education. . . ." 20 U.S.C. 1401(17); 34 C.F.R. 300.13(a). Both the EHA-B statute and regulations specify physical therapy and occupational therapy as examples of related services that school districts can make available under EHA-B. 20 U.S.C. 1401(17); 34 C.F.R. 300.13(b)(5), (7). Thus, the statute and regulations reflect the recognition that required related services for a child with a handicap could include services traditionally regarded as health-related services, in circumstances where the child needs those services to benefit from special education. Indeed, EHA-B mandates the provision of therapeutic services, where such services would [illegible]essary for a child with a particular handicapping [illegible] to receive an appropriate education.

It should be borne in mind that while the statute also recognizes a classification of related services known as "medical services," that classification is limited to "such medical services . . . for diagnostic and evaluation purposes only." 20 U.S.C. 1401(17).*

The regulations for EHA-B further limit medical services includable as related services to those ". . . services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services." 34 C.F.R. 300.13(b)(4). "Physical therapy," however, is defined in the EHA-B regulations to mean "services provided by a qualified physical therapist." 34 C.F.R. 300.13(b)(7). EHA-B defines "occupational therapy" by describing only the nature of the services as:

> (i) Improving, developing, or restoring functions impaired or lost through illness, injury or deprivation; (ii) improving ability to perform tasks for independent functioning when functions are impaired or lost; and (iii) preventing, through early intervention, initial or further impairment or loss of function. 34 C.F.R. 300.13(b)(5).

Thus, physical and occupational therapy are clearly includable related services under EHA-B, even where qualified therapists must obtain certification from licensing boards staffed with medical personnel.

In sum, the pertinent inquiry to be made in determining the extent of a school district's obligation to provide physical and occupational therapy is whether the child needs the services in order to benefit from special education. Please keep in mind that such an inquiry is dependent on the facts and circumstances of a particular case and therefore must be made on a case-by-case basis. Any disagreements your client may have with the school district's determination to deny physical or occupational therapy services would be appropriate matters for an impartial EHA-B due process hearing under 34 C.F.R. 300.506(a). You may also be interested in reviewing a reported case on this issue — *Maurits v. Board of Education of Harford County* (1983-84 EHLR DEC. 555.364 (D. Md., 1983)).

Your letter also raises several questions concerning standards for developing IEP goals and objectives. The content of each child's IEP must be individually determined and is left to the discretion of the participants at the IEP meeting. Appendix C to 34 C.F.R. Part 300 (Response to Question No. 36) [hereinafter cited as App. C]. The EHA-B regulations provide that the child's IEP include statements of the child's present levels of educational performance; annual goals, including short-term instructional objectives; and the specific special education and related services to be provided the child. 34 C.F.R. 300.346(a), (b), and (c). The Department has emphasized that these components are interrelated and can include both academic and nonacademic skills. See App. C, Question No. 36.

One issue raised in your letter concerns the time period to which the annual goals must correspond. The Department has stated that "[t]he annual goals in the IEP are statements which are designed to reflect what a handicapped child can reasonably be expected to accomplish within a 12-month period. . .," and must reflect the child's present level of education performance. (*Id.* Question No. 38.) As is the case with special education services, the annual goals for related services must be developed to include instruction designed to assist the child to benefit educationally. *See Board of Education of Hendrick-Hudson Central School District v. Rowley*, 458 U.S. 176 (1982). If proficiency in certain motor skills, for example, is a prerequisite to meeting a handicapped child's unique needs, physical or occupational therapy, or both types of services, may be required by a child with a particular handicapping condition and would, therefore, be reflected in the statements of annual goals. There may, however, be a

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While the courts have begun to address the nature and scope of ervices not expressly authorized by statute, but nonetheless within e intent of Congress (*see Irving Independent School District v.* [illegible]3-84 EHLR DEC. 555:511 (1983) and related cases), these [illegible] do not edify the clear intent of the law as it applies to the [illegible]presented in your letter.

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legitimate issue of timing in providing such services if the child is in the early elementary grades and will not be receiving prevocational and vocational instruction until some date in the future, as referred to in your letter. Thus, the proposed annual goals referenced in question Nos. 3, 4, and 5 of your letter can only constitute permissible "annual goals" if they are related to the child's special education program during the upcoming twelve-month period for which the goals have been designed. Please bear in mind that the planning process is not limited to a one-year span, although the establishment of specific goals and objectives is so limited. Thus, if one can anticipate a need that must be met in the next several years, and, in order to be prepared for that, it is appropriate to establish goals and objectives for prerequisite skills in the current year, then such needs may well be addressed. If the client's parents wish to challenge the school district's determinations regarding the child's IEP, they are entitled to request a due process hearing under 34 C.F.R. 300.506(a).

Another issue in your letter concerns the school district's obligation under 34 C.F.R. 300.344 to include, at the parent's request, a physical therapist or occupational therapist as a necessary participant at the IEP meeting. While EHA-B regulations require the participation of certain individuals at the IEP meeting (34 C.F.R. 300.344(a)(1)-(4)), related services personnel are not required to attend. However, if a child with a handicap has an identified need for related services, it would be appropriate for the related services personnel to attend the meeting or otherwise be involved in developing the IEP. In the case of your client, if the evaluation indicates the need for physical or occupational therapy, a qualified provider of that service could either attend the IEP meeting or provide written recommendations concerning the nature, frequency, and amount of services to be provided. App. C, Question No. 23. Under such circumstances, EHA-B would require the public agency [in this case, the school district] to pay expenses associated with such provider's participation at the IEP meeting, if such person is employed by the school district. However, where the physical therapist or occupational therapist is not employed by the school district, it would not be appropriate for the school district to take steps to ensure such provider's participation at the IEP meeting, regardless of the parent's request. Thus, even though EHA-B affords both the parent or the agency the discretion to bring a qualified service provider to an IEP meeting (34 C.F.R. 300.344(a)(5)), we find nothing in EHA-B which requires a school district to reimburse parents for the participation of a physical or occupational therapist not employed by the public agency.

Your letter also raises a concern regarding your client's participation in a program of specially designed physical education (PE) and indicates that the child is currently participating in the regular PE program, with modifications prescribed in her IEP. The EHA-B regulations define specially designed PE to include "the development of . . . physical and motor fitness" and "fundamental motor skills and patterns." 34 C.F.R. 300.14(b)(2)(i)(A)-(B). Thus, un EHA-B's definition of "special education," specially designed PE includes "special physical education, adapted physical education, movement education, and motor development." 34 C.F.R. 300.14(b)(2)(ii). However, the EHA-B regulations provide that a child cannot participate in a program of specially designed PE unless the child's IEP specifies the need for such instruction. 34 C.F.R. 300.307(b)(2). Otherwise, the regulations presume that the child will participate in the regular PE program. 34 C.F.R. 300.307(b). Because the concern raised in your letter relates to the content of the child's IEP, the most appropriate mechanism for addressing this issue is an EHA-B due process hearing under 34 C.F.R. 300.506(a).

We hope that you have found the above responses helpful in assisting clients. Thank you for bringing these matters to our attention.

Madeleine Will
Assistant Secretary
Office of Special Education
and Rehabilitative Services

Inquiry by: Charles A. Presto
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Atlanta, GA 30338

Digest of Inquiry
(February 18, 1988)

- May an IEP meeting be terminated if the parent does not agree with the district's proposed label of the handicapping condition?
- May a parent who disagrees with the proposed classification be excluded from participation in the IEP meeting?
- May the educational records of a special education student be released to an outside psychologist hired by the district as an expert witness?
- Are there any limitations on the source of funds used by a school district for its legal fees in a due proce hearing?

not be able to exclude any child with medical clearance to go to school. All the in school health services the child may require, if not required to be provided by a physician, will be related services.

- School health services can be provided by a wide range of school staff other than nurses. Aides with various skills are able to provide a wide range of services to children with health services needs. However, schools cannot require parents to provide in school health services or to be responsible for in school aides, nurses or supplies. Likewise, schools cannot require parents to sign liability waivers as a condition of having their child receive school health services.

- To be a related service, the health services must be required during the course of the school day. If the service can be performed before or after school, then the school is not required to undertake the activity.

- Also, the EHA contains a separate provision that limits the services of a physician. EHA services that will be performed by a physician are limited to diagnostic and evaluation services, as compared to ongoing treatment services (34 C.F.R. Section 300.13(b)(4), Medical Services). Ongoing treatment services are available as a related service only if they can be performed by a school nurse or lesser skilled staff (e.g., aid, teacher, principal).[28]

- To determine the scope of school health services, as well as the qualifications of school nurses and health staff, other provisions of state law must be reviewed. States may have professional licensure requirements for the health professions (RN, LPN, nurses aides) and limit duties for each skill level.[29] In addition, a review should be performed of the typical services a school nurse or health staff will perform for children without handicaps. Some nurses provide very few services; others, a wide variety. It is clear, however, that services provided to children without handicaps cannot be denied to children with them.

- Finally, consideration must be given as to whether the proposed service will constitute an "undue burden" on the school district.

- All of these considerations are based on the Supreme Court's 1984 decision in *Irving Independent School District v. Tatro*. In that case, the Court required the school to perform a catheterization procedure on an elementary grade child. The Court noted that the services were needed to "permit a child to remain at school during the day [and] are no less related to the effort to educate than are services that enable the child to reach, enter, or exit the school."

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[28] The fact that a physician is ultimately writing the nursing plan, or otherwise supervising the in-school services is not grounds for invoking the "medical services" limitation. All nursing services must be at the direction of a physician. The limitation applies to services that only a physician can perform.

[29] Caution is required if attempts are made to compare cases reporting on the health care services provided to children in different states. To date, none of these cases has considered whether the reason a different level of skill is required to meet the child's needs is that the state "nurse practice act" mandates it. Therefore, two children with similar needs could be viewed as different, because the child who requires the more skilled person is mistakenly viewed as more severely impaired.

- Based on *Tatro*, and the EHA rules for "medical" and "school health" services, school nurses and health staff have been ordered to administer medications, conduct blood testing (e.g., for a child with diabetes), perform tracheostomy suctioning, catheterization and other similar services.

- To date, no case has found that a particular service would constitute an "undue burden." For example, just as schools have had to hire a wide range of specially trained staff to address the educational needs of children with handicaps, there is no reason to allow a school to claim its nurse has never done the particular service before, or that the nurse is itinerant, serving more than one school per day. The school should be required to hire an appropriately trained nurse or aide.

- If a child needs 1:1 services, no exception should exist: other children have aides to assist with mainstreaming, for behavioral control, or other reasons. No distinction can be made between an aide who is present for health as compared to these other reasons.

- Finally, cost never can be a justification denying a school health service. For a health service, cost issues probably are a mask for other reasons related to the unwillingness of the school to serve children with special health care needs. Most often, any possible cost savings are illusory, or insignificant.

- Cost issues cannot factor into EHA decision making unless the two options being considered are equally appropriate. There obviously can be no claim that it is appropriate "not" to provide a needed health service. For this reason, cost considerations arise in terms of providing an in-school program, or home instruction, where the health services are provided by a family member or other person. However, home instruction never can satisfy the least restrictive setting rules if an in-school placement can be considered. If a child is medically able to be in school, as noted by his/her physician, then the school should be responsible for providing the supplemental health aids and services that will maintain the in school placement.

- Only a few cases have concluded that needed health services were not required: when the services of a physician were involved, and in two nursing cases, in which extensive procedures were required, and in which 1:1 constant monitoring was involved. In both nursing cases the courts likened the services performed to be those of a physician. These cases, which were brought in New York and Pennsylvania, have been rejected by the more recent nursing cases, in Michigan and Utah, which hold 1:1 nursing services are EHA related services.

- In *Tatro*, note was taken that the child was asking only for the catheterization service to be provided, not the related equipment. However, no exception exists to require the parent to pay for, or for insurance to pay for any equipment, including equipment and supplies needed to perform a health related service. For example, a school with a child with unstable diabetes, cannot require the parent to supply an "accucheck" device to perform periodic blood testing.

f. Any Other Developmental, Corrective And Support Services That May Be Needed

- The related services regulation states that the list is not exhaustive (34 C.F.R. Section 300.13 (Comment)). If other types of services or personnel can be identified, and can meet the requirement that it is needed to enable the child to benefit from special education, then the service or staff should be provided.

- The addition of "assistive technology devices" and "assistive technology services" to the list of definitions in Section 1401(a) should be viewed as making them both among the services that can be included in a child's IEP as related services. Even before they were expressly stated in the EHA, the OSEP letter made clear that assistive technology could be a related service. The 1990 EHA Amendments make this conclusion inescapable.

4. "Least Restrictive Environment"

- The EHA integration mandates require special education and related services to be provided in particular settings. The educational setting or "placement" for a handicapped child must be, "to the maximum extent appropriate, in the least restrictive environment," or "LRE."

- "Least restrictive environment" uses as a comparison the educational placement the child would be in if s/he had no handicaps. This most likely would be the local school, closest to the child's home, in a regular education class with other children who are not handicapped. Handicapped children also have the right to attend such schools and classes, but may also be placed elsewhere, only if their needs require it.

- The LRE requirement is one of the conditions of eligibility for EHA funding. States must assure that

> to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily....(20 U.S.C. Section 1412(5)(B); 1414(a)(1)(C)(iv)).

- To implement the LRE requirement, school districts must make available a "continuum of placements." (34 C.F.R. Section 300.550-.556). This means that a district must operate and/or contract for a wide range of educational settings. The variety of those settings will be determined by the individual needs of the district's students. These settings may include regular education classes, resource room classes, self contained classes, private day schools, residential placements, and home and hospital instruction.

* Of greatest importance is that throughout the range of placements, handicapped children must receive the special education and related services, as well as any supplementary aids and services they may require.

* There is no definition in the EHA or regulations for the term "supplementary aids and services." Thus, it is not clear whether the term is co-extensive with, or expands upon the definition of related services. In any event, it is clear that the term is important because it is specifically tied to the child's placement. Supplementary aids and services can be viewed as the devices and services children require in order to achieve or most closely approximate the abilities of children who are not handicapped.

* In addition, the LRE requirement must be applied to every course and every activity. Supplemental aids and services may be available, or may not even be needed for a handicapped child to participate in some academic subjects, "specials" (lunch, gym, music, art, assemblies, field trips) or extra curricular activities. A child's IEP must state the degree to which the child will be in regular education; LRE requires schools to consider each piece of the school experience separately.

* The supplemental aids and services requirement is extremely important in regard to assistive technology. The August 10, 1990 OSEP letter expressly states that assistive technology can be considered an LRE factor. As an LRE factor, assistive technology is specifically tied to maximizing the child's ability to be in regular education, and to participate in learning and other activities with children who are not handicapped. LRE requires school districts to presume a handicapped child will be educated in a regular class. LRE challenges the schools to find supplemental aids and services to keep the child in that placement. Only if none are available to meet that goal can a child be removed and placed in separate, self contained classes.

5. "Staff Development"

* The EHA forces states and school districts to change the way handicapped children are educated. New programs, new services, new ways of thinking are required. The EHA also recognizes that to be successful, the instructional staff, the administrative staff, and the services staff all must be aware of the goals of the statute, be appropriately trained to carry out its goals, and be aware of, and amenable to replicating successful programs in other districts. The EHA requires states, and school districts to assure that all of these staff supports will exist (20 U.S.C. Sections 1413(a)(3); 1414(a)(c)(i); 34 C.F.R. Section 300.380 - .387).

* The EHA's staff development requirements are extremely important in regard to assistive technology. One of the greatest issues with regard to special education is the

lack of knowledge about successful programs, and a failure to adopt new approaches and techniques. Introducing and assimilating assistive technology into the schools is made more difficult by this failure.

- The 1990 EHA Amendment adding "assistive technology service" should be read in conjunction with the "staff development" duty. It includes training for professionals as an assistive technology service (Section 1401(a)(26)(F)). Thus, individuals with disabilities should be able to compel school staff to become familiar with the potential of assistive technology and then make it a part of the IEP.

- An essential function of state Tech Act staff must be to educate state education department staff of their mandate under the EHA to provide training, in-service training, and research reports, about assistive technology. Tech Act staff also must remind state staff of their duty to require the adoption of successful programs demonstrated elsewhere. In particular, they must explain how assistive technology can benefit handicapped children, and that state education department staff must make this information available to local school districts.

- At the local school district level, the Tech Act staff must educate local school officials of their duty to consider assistive technology as a supplemental aid or service before a handicapped child is proposed for removal from regular education and placement in a self contained class. They must be informed of the ability of assistive technology to modify the curriculum as well as the learning environment for children with handicaps, they must be informed how to conduct proper assistive technology evaluations, and how to develop in-school staff skills to work with children who will be using assistive technology.

- State Tech Act staff also can wield a club: the EHA requires states and local school districts to conduct trainings and in-service trainings, to hire appropriately skilled staff, and to adopt successful programs. It is obvious that assistive technology has been used successfully in many settings; Tech Act staff can insist that the state adopt policies and programs that will permit those programs to be reproduced throughout the state.

6. "Procedural Safeguards"

- All aspects of the educational program for a child with handicaps must be developed according to a set of standardized procedures. These procedures are described as "safeguards" because they ensure the special education program is both "individualized" and "appropriate," i.e., that it will teach meaningful skills and be taught with recognition of the unique characteristics of the child. The EHA rejects the past practice of school districts offering "one size fits all" educational programs that may be meaningless to children with handicaps.

- The procedural safeguards serve an additional role: they are designed to create a high degree of uniformity and predictability despite the extraordinarily diverse characteristics of the children themselves and of the school districts throughout the United States. Children with similar handicaps should be able to receive the same "Free Appropriate Public Education" regardless whether they live in a wealthy or poor, urban or rural, large or small school district.

- The procedural safeguards address 5 issues:

  (a) identification of the handicapping condition;
  (b) development of the special education program;
  (c) implementation of the program;
  (d) review of the program; and
  (e) resolution of disputes.

a. Identification of the Handicapping Condition

- The EHA imposes an affirmative duty on school and state education officials to engage in a "child find" system to identify children who have handicapping conditions. This is one of the assurances states must include in their State Plans (20 U.S.C. Section 1412(2)(C); 34 C.F.R. Section 300.300).

- At the local school level, staff and administrators are required to consider the possibility of a handicap when they observe children performing or behaving poorly.

- Parents, teachers, school administrators and physicians are all expected to make a "referral" of a child to school authorities when they believe s/he may be handicapped and require special education and related services.

- Once a referral is made, a meeting is scheduled with evaluation staff at the local school district and the child's parents to identify the types of information that will be needed to determine if the child is handicapped. Among the things to be discussed are the basis for the referral; the types of evaluations to be performed; and who and when they will be performed.

- The EHA imposes no special data requirements for a child to establish that s/he is "handicapped." No specific medical or other tests are stated in the Act or rules. Instead, the Act and rules state the definitions of the conditions that will result in a child being found "handicapped." As long as the evaluations are professionally accepted, and provide the required data, they should be sufficient. Of course, it is possible that the results of tests and evaluations will differ, or be subject to different interpretations. In that event, a separate procedural safeguard is available to resolve disputes.

- The EHA requires these evaluations to be conducted as expeditiously as possible after the referral is made. A mandate for quick action will allow the child to receive special education and related services as soon as possible after his/her handicapping conditions are confirmed, their extent is established, and an appropriate program and placement can be developed.

* The definition of "assistive technology service" now makes clear that the evaluations to be conducted can include an evaluation of the individual's need for, and potential to benefit from assistive technology (Section 1401(a)(26)(A)). Individuals with handicaps can now demand that they be evaluated under this provision, and then be provided whatever devices and services are deemed appropriate as a result of those evaluations.

b. Development of the Special Education Program

* Once the evaluations are complete, a meeting must be scheduled with the school district's IEP Committee. The IEP committee is required to write, review and revise IEPs (34 C.F.R. Section 300.343(a)).

* Although, as noted above, the definition of "assistive technology service" includes evaluation, the EHA Amendments did not add an express requirement that a child being considered for classification and the development of an IEP receive an assistive technology evaluation. To obtain such an evaluation, it may have to be demanded.

* Unfortunately, the absence of an express evaluation requirement may create a barrier to the introduction of assistive technology: neither the parents nor school officials may be aware of the potential of assistive technology to assist children; also, parents may not be aware of their right, or be sufficiently skillful to require a school district to conduct such an evaluation, or to pay for an independent evaluation.

* Yet parents do have the right to demand an assistive technology evaluation, or any other evaluation that may help identify the existence or characteristics of a child's handicap. In addition, parents have the right to express their dissatisfaction with an evaluation by requesting that the school district pay for an independent evaluation at its own expense (34 C.F.R. Section 300.503). If the school refuses to perform an evaluation, or refuses to consent to an independent evaluation, the parents can either request a hearing to challenge the school's decision, or secure the evaluation at their own expense and later seek reimbursement from the school district.

* In addition, as noted in the Least Restrictive Environment section, before a child can be considered for other than a regular classroom placement, an assistive technology evaluation should be a requirement.

* Tech Act staff will provide enormous benefits to handicapped children throughout their state if they can convince their state education department to order such evaluations in all their school districts, and can educate parents and advocates to demand such evaluations at the local school district level.

c. Implementation of the Special Education Program

* The workproduct of the IEP Committee is an IEP which states the special

education and related services the child is to receive during that particular school year. The IEP must then be implemented as written.

- In addition, IEPs must be implemented immediately after they are developed (34 C.F.R. Section 300.342(b)(2), Comment). Schools cannot tell parents that they must wait for next year, or that there is no money, or offer any other excuse that would delay the full implementation of the IEP.

- Equally true is that once implementation of an IEP has begun, the school can make no unilateral changes to its terms under any circumstances. Services cannot be changed in frequency or duration, or substitutions be made, and placements cannot be changed without first notifying the parents and scheduling a meeting of the IEP committee. Only the committee, with parent notice and participation can change an IEP.

d. Review of the Special Education Program

- School districts have an affirmative duty to inform parents and the IEP Committee when it recognizes that something in the IEP is not working; or that any element of the IEP is not being implemented as written (34 C.F.R. Section 300.504(a)). Parents have the same right to reconvene the IEP Committee at any time to review the implementation and continued "appropriateness" of the IEP.

- In addition, every IEP must be reviewed at least annually; usually, an IEP is written in the spring (May or June) of one school year to be applicable to the child's program for the next school year. School districts also are required to conduct comprehensive re-evaluations of all handicapped children at least once every three years.

- Parents who learn that assistive technology may be appropriate for their child may reconvene the IEP committee at any time to demand that an assistive technology evaluation be conducted. Tech Act staff should make parents throughout their state aware of this right, and monitor parent requests for assistive technology evaluations. Tech Act staff may have to develop lists of experts to conduct these evaluations.

e. Dispute Resolution

- The EHA contains an extensive set of procedures for resolving parent-school disputes (20 U.S.C. Section 1415).

- First, there is the IEP Committee. That body has the authority to recommend any special education and related service any child may need.

- If parents are dissatisfied with any aspect of the IEP, or if they do not believe it is being implemented as written, they may request an impartial hearing before an independent hearing officer. The hearing is a full trial type hearing, with the opportunity for each side to have an attorney, to review records, to compel witnesses to appear, and to cross examine them. A verbatim record of a hearing is maintained, and a written decision will be issued.

* If either the parents or school district disagree with the hearing decision, further review is available to the state Commissioner of Education, and/or to the state or federal courts.

* Of greatest importance is that the EHA dispute resolution process attempts to take into account the importance that each child's program be "appropriate." Therefore, hearings must be decided not more than 45 days after they were first requested.

* In addition, the EHA contains a "stay put" provision, meaning that as long as a dispute continues, the child's program and placement will continue unless the parents and school district, or state education department agree to an alternative program or placement. For a child who was in regular education and is being considered for a self contained placement, the "status quo" provisions are extremely valuable. They protect the child's regular education placement until all questions about the availability of assistive technology and other program adaptations have been resolved.

7. "Appropriate Education" Barrier

* The EHA has vague standards in regard to the quality of the programs and services school districts must offer. Schools are not required to provide programs and services that will "maximize" the learning or potential of children with handicaps. They do not have to offer the "best" programs and services either. However, school districts should not be permitted to claim assistive technology is "best" while not having access to these devices and services is "appropriate."

* Schools must provide programs and services that are "appropriate," i.e., that allow a child to "benefit." Benefit is measured for children in regular education by the ability to go from grade to grade. Ultimately, the measure of success for these children is graduation.

* For children who are not in regular education, or for whom graduation is not an expectation, "benefit" still must be a comparative term. But benefit in relation to what? The answer is that there should be a long range goal for all of these children. As early as possible in the child's education, reasonable expectations for his or her future at the end of his EHA entitlement should be set. These expectations should not be rooted in outmoded, biased, or stereotyped thinking, but should be realistic goals for the entire educational experience. The 1990 EHA Amendments require that "transitional planning", i.e., planning for the individual after his/her EHA entitlement expires, must be part of an IEP no later than age 16, or at any earlier age, if appropriate (20 U.S.C. Sections 1401(a) (19) and (a) (20) (D)).

* With a long range goal in mind, the concept of "benefit" is more clear: the educational program must allow the child to make measured progress toward that goal in every school year. Special education will move the child in that direction; related services

will enable the child to benefit from the special education. Assistive technology can be part of those related services as well as part of the specialized instruction that comprises special education.

* If that process has worked to date without assistive technology, how then can assistive technology be introduced? The answer is that just as new services can be introduced into a child's IEP, so too can the long range picture be changed. With assistive technology, the child's expectations at the conclusion of school may be far better than before, and be far closer to the goals of non-handicapped students.

* As the long range goal changes, so too can the special education and related services, including assistive technology, that are developed and provided to get the child there.

8. "Lack of Basic Knowledge" Barrier

* The EHA mandates that information about new ways to successfully educate and integrate children with handicaps be distributed as widely as possible, and that successful programs, equipment, and materials be adopted in other school districts (20 U.S.C. Section 1413(a)(3); 1414(a)(C)(i)). This mandate is an invitation for new information to be distributed throughout the country about the important benefits assistive technology can provide to handicapped children (See 20 Section 1401 (a)(26)(F)).

* Yet this generally has not occurred. There are enormous differences in the way handicapped children with similar needs are educated within school districts, between neighboring school districts, across the states, and around the country. Good programs are few and far between, and information about them is not distributed or does not lead to replication.

* School district staff, regardless of the EHA mandates to the contrary, are unlikely to be subscribers to research journals, frequent attendees at conferences, or otherwise seek out or receive the training necessary to introduce assistive technology into their schools. Local school districts vary greatly in thinking and practice about how assistive technology can be used to maximize the physical, academic, social and societal integration of handicapped children.

* At present, the size, sophistication, financial base, and geographic location of the school districts, the financial and educational level of the parents, and their access to trained advocates, all will have an important bearing on a child's ability to secure appropriate, high quality special education services in the least restrictive setting, and in particular, assistive technology devices and services.

9. "EHA Funding Levels" Barrier

* One explanation, but not a justification for the lack of school district and state education department efforts to introduce assistive technology into the schools is the

perceived underfunding of special education in general. School districts are likely to be uniform in their complaint that EHA mandates are issued in total disregard for their costs.

- The EHA is one of the least well funded federal programs for persons with handicaps. The federal government once intended to provide funding capable of meeting 40% of the costs of special education programs and services at the local level, but in fact, the federal share is between 8-12% of those costs.

- In addition, assistive technology is perceived as expensive. It is rare that school districts will voluntarily establish policies to promote assistive technology evaluation, acquisition and use. And, despite their status as a taxing authority in most, if not all states, school districts will claim they cannot raise school taxes to obtain the money for new programs, equipment, staff and services.

- Here, Tech Act staff must work with parents and advocates to force change. Additional funding is not the answer, nor is insufficient funding the real issue. School officials will readily say that the district provides whatever is needed to run the special education program; that it is funded first, and if cuts are to be made, they come from other sources. If this is true, then assistive technology should be readily available, yet it is not.

- By pressing for assistive technology availability, cost can be seen as favoring assistive technology use. Many school districts rely on cooperative programs among many districts for the education of handicapped children. These services are provided by contract, and are expensive. Any child who can remain in regular education with assistive technology will save the district tens of thousands of dollars above and beyond the cost of the technology when measured against the number of years the child will be in school. Even if the school operates its own special education programs, the costs of maintaining a child in a regular class may be less than the cost of providing a self contained classroom.

10. "Ownership" Barrier

- A third barrier is the question of "ownership." Schools may resist obtaining assistive technology because a child ultimately will leave school, and leave behind a device that was expensive to acquire, and potentially useless to any other child.

- A variant is that the district may acquire assistive technology for children but may claim that the devices must remain on school property, and must not be taken home by the student after school hours, on weekends, or during vacations.

- These excuses arise from lack of imagination, and can easily be solved. Schools can develop cooperative agreements with vocational rehabilitation programs, employers, and others who will train or employ handicapped children after they leave school. A child who used an augmentative communication device in school will most certainly have to obtain a new one from the vocational rehabilitation agency if the school does not allow the child to graduate with it. No insurmountable barrier exists to prevent the vocational rehabilitation agency from reimbursing the school for the device, rather than having to buy a second device, assuming it still is being manufactured. This example can be applied to any assistive technology.[30]

* The "school only" rule is likely to be a violation of Section 504. If a child uses a computer as a notebook, or as a textbook, then as long as the school district gives homework, or otherwise allows children to take books home, they also must provide the same opportunity to a child with handicaps. Wheelchairs are likely to be less of a problem: many children will have a second chair at home, or be able to get around on crutches or with a scooter. The wheelchair is needed only to address the many location changes and distances within the school setting. An augmentative communication device, another typical assistive technology device, also serves no purpose staying at school. A child is expected to practice his/her lessons at home, and one of the goals on the child's IEP will be to increase speed and flexibility with the device. To say those goals can only be achieved in school is incorrect.

* Schools that adopt any of these practices should be challenged from both the individual level, through impartial hearings; and from the state education department level as a matter of policy.

Part B. Early Intervention Services For Infants & Toddlers

I. Introduction

* In 1986, Congress amended the EHA to add a new Part H, an early intervention program for infants and toddlers. The program will serve children from birth through age 2 (36 months). EHA Amendments of 1986, Public Law No. 99-457, adding 20 U.S.C. Sections 1471 - 1485.

* Early intervention is a preventive services program. Congress concluded that the earlier services are provided to handicapped children, or those at risk of developmental delays, the greater the potential (a) to prevent the handicap ever from significantly limiting the child's functioning; or (b) to lessen the significance of any limitations that will arise.

> The Congress finds that there is an urgent and substantial need-
> (1) to enhance the development of handicapped infants and toddlers and to minimize their potential for developmental delay;
> (2) to reduce the educational costs to our society, including our Nation's schools, by minimizing the need for special education and related services after handicapped infants and toddlers reach school age;
> (3) to minimize the likelihood of institutionalization of handicapped

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[30] The federal regulations governing equipment acquisition expressly permit disposal of equipment to other programs receiving federal financial assistance. Nothing should bar a school district from reaching an interagency agreement with a state vocational rehabilitation program to transfer assistive technology provided as part of a child's FAPE (34 C.F.R. Section 80.32(c)).

individuals and maximize the potential for their independent living in society; and

(4) to enhance the capacity of families to meet the special needs of their handicapped infants and toddlers (20 U.S.C. Section 1471(a)).

- EHA Part H, the early intervention program, was created to supply financial assistance to states:

(1) to develop and implement a statewide, comprehensive, coordinated, multi-disciplinary, interagency program of early intervention services for handicapped infants and toddlers and their families;
(2) to facilitate the coordination of payment for early intervention services from Federal, State, local and private sources (including public and private insurance coverage) and
(3) to enhance their capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to handicapped infants, toddlers and their families.

- Part H is a unique program. It states three goals: to coordinate the many services programs that currently exist, to ensure that infants, toddlers and their families who need those services actually receive them, and where gaps in services exist, to provide them directly.

- Its target population also is unique: it addresses not only infants and toddlers with handicaps, but their family. The law recognizes that families are instrumental in aiding, and at times retarding the physical, cognitive, language and speech, psychosocial, and self help development of children. Therefore, Part H focuses on the needs of families as well.

- The core concept of Part H is coordination of services. It operates at two levels: state and local. The law requires states to designate a lead agency to address the state-level coordination issues; it also mandates the assignment of a case manager to each child and family to coordinate the local level issues. (The lead agency for each state under Part H is annexed.)

- Part H identifies 14 components of the state system:

- state definition of developmental delay
- central information directory
- timetables for initiation of services
- personnel development system
- personnel standards
- procedural safeguards
- designation of lead agency

- public awareness program
- child find system
- evaluation & assessment
- Individualized Family Service Plans
- contracting policy
- cost reimbursement policy
- data collection

- Viewed in its entirety, Part H is an aggressive program that rejects the inevitability of handicap. Assistive technology can definitely aid in achieving the goals of this program. For this reason, assistive technology funding through Part H, as well as through the many other service systems that will provide early intervention services, should be viewed not only as available, but as mandated.

- Unfortunately, Part H and its regulations are not written in a manner that is easily understandable. The statute and regulations are a maze in which it is easy to become lost. Yet, understanding these rules is essential for the state "Tech Act" staff: the early intervention program is extremely important to infants and toddlers with handicaps, and Tech Act staff can have a significant role in seeing that its enormous potential is reached.

II. State Plan Requirements

- Part H provides financial assistance to states for a five year period to create the "statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services" outlined in the EHA. Grants under Part H are tied to the state progressing toward having a system in place at the start of the fifth year of funding.

A. First Two Years

- In the first two years, states are required to create the administrative structures that will implement the early intervention program. Evaluations and services are not required in this period.

- Instead, states must designate a lead agency to be responsible for planning, developing and implementing the statewide system (20 U.S.C. Section 1475(a); 1478(a)(1)). The state also must create an Interagency Coordinating Council which will serve as an advisory body to assist the lead agency (Sections 1474; 1478(a)(2); 1482. See 34 C.F.R. Sections 303.141-.146; 147).

B. Years Three and Four

- By the start of year three, the states must assure that it is the state's policy to develop and implement a statewide early intervention system as required by Part H, and that the system will be in place not later than the start of the fourth year of the grant (34 C.F.R. Section 303.148(b)).

Early Intervention Program for Handicapped Infants & Toddlers

State Lead Agencies

State	Lead Agency
Alabama	Education; Rehabilitation; CCS
Alaska	Health & Social Services; MCH
Arizona	Economic Security; DD
Arkansas	Human Services; DD
California	Developmental Services; Community Services
Colorado	Education; Special Education Services
Connecticut	Education; Early Childhood
Delaware	Public Instruction; Exceptional Children & Special Programs
D.C.	Human Services; Early Childhood Development
Florida	Education; Early Intervention
Georgia	Human Resources; MH-MR-SA
Hawaii	Health; CCS
Idaho	Health & Welfare; DD
Illinois	St. Bd. of Education; Early Childhood Program Unit
Indiana	Mental Health
Iowa	Education; Special Education
Kansas	Health & Environment; MCH
Kentucky	Human Resources; MH-MR
Louisiana	Education; Special Education
Maine	Interdepartmental Committee

State	Lead Agency
Maryland	Ofc of Special Secretary, Children, Youth & Families
Massachusetts	Public Health; Early Childhood
Michigan	Education; Early Childhood Education
Minnesota	Education
Mississippi	Health
Missouri	Elementary & Secondary Education; Special Education
Montana	Social & Rehabilitation Services; DD
Nebraska	Education; Special Education
Nevada	Human Resources; MH
New Hampshire	Education; Special Education
New Jersey	Education; Special Education
New Mexico	Health & Environment; DD
New York	Health; Early Intervention
North Carolina	Human Resources; MH-MR-SA
North Dakota	Human Services; DD
Ohio	Health; MCH
Oklahoma	Education; Special Education
Oregon	Human Resources; MH
Pennsylvania	Public Welfare; MR
Rhode Island	Interagency Coordinating Council
South Carolina	Health & Environmental Control; Children's Health
South Dakota	Education & Cultural Affairs; Special Education

State	Lead Agency
Tennessee	Education; Special Education
Texas	Interagency Council on Early Childhood Intervention
Utah	Health; Family Health Services
Vermont	Education; Special Education
Virginia	MH-MR-SA; Children & Youth Service
Washington	Social & Health Services
West Virginia	Health & Human Services; Behavioral Health Services
Wisconsin	Health & Social Services; Community Services
Wyoming	Health & Social Services; Community Programs

Key

CCS	Crippled Children's Services
DD	Developmental Disabilities
MCH	Maternal & Child Health
MH	Mental Health
MR	Mental Retardation
SA	Substance Abuse

Source: Early Childhood Reporter, Vol. 1, Issue 1, at p. 11 (Jan. 1990).

- The components of that policy must include the state's laws and rules that will become effective when the statewide system is implemented. Those laws and rules must include the definition of the children and families who will be eligible for early intervention services. Under Part H the states have discretion to determine eligibility. States must supply a definition for "developmental delay," and at the state's option, "at risk" children (34 C.F.R. Section 303.160; .300).

- By year four the state also must have a central, statewide registry of all services providers, evaluators, and other sources of assistance to parents (34 C.F.R. Sections 300.161; .301).

- The states must have in place a comprehensive "child find" system, capable of identifying all infants and toddlers and their families who may be eligible for services under the state program (34 C.F.R. Section 303.164).

- The states must also supply a timetable by which all of the components of the state system will be in place (34 C.F.R. Section 303.162).

- Another requirement is for the state to have created a program by which the public will become aware of available early intervention services (34 C.F.R Section 303.163).

- In addition, by year four, the state must be providing all eligible children and families timely evaluations and assessments; preparing "individualized family services plans" ("IFSP"); and providing case management services (34 C.F.R. Section 303.341).

C. Year Five and Thereafter

- By the fifth year of Part H funding, the state must have the entire system of early intervention services in place, and operating (34 C.F.R. Section 303.152).

- The ultimate system must identify the existing programs which will provide services, as well the services that the Part H program will provide directly (34 C.F.R. Section 303.144(d)).

III. Individual Eligibility Criteria

- As noted above, Part H does not establish all the eligibility criteria for early intervention services. The Act states that it is intended to benefit:

> handicapped infants and toddlers, from birth to age two inclusive [age 0-36 months], who need early intervention services because they --
>
> (A) are experiencing developmental delays, as measured by appropriate

diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or

(B) have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.

Such term may also include, at a State's discretion, individuals from birth to age 2, inclusive, who are at risk of having substantial developmental delays if early intervention services are not provided (20 U.S.C. Section 1472(1)).

- The terms "developmental delay" and "at risk" are not defined in the Act. Instead, each state is required to supply its own definition as a condition of funding (20 U.S.C. Section 1472(3)).

- In addition, there is no specific list of the conditions that will meet the criterion in subpart (B). The Part H regulations offer specific conditions as suggestions, but not requirements (See 34 C.F.R. Section 303.16(note)).

A. Financial Eligibility Criteria Can Be Set For Certain Services

- Unlike the EHA programs for children age 3 - 21, early intervention services do not have to be provided "at no cost to the parent." The Part H rules require states to develop funding policies that set out what early intervention services will be provided at no cost (34 C.F.R. Sections 303.19; .520). If costs are to be imposed, financial eligibility rules must be established.

- Some services must be provided without cost. These include: the child find effort, the evaluations and assessments to determine the needs of the child and family; the development and review of the IFSP; all case management services; and all of the procedural safeguards available to resolve disputes (34 C.F.R. Section 303.521).

- In addition, both financial and other criteria may have to be met for particular services that are provided by existing services programs funded by sources other than Part H. (e.g., Medicaid). The Act places a premium on interagency coordination, with an emphasis being placed on agreements involving financial responsibility (34 C.F.R. Section 303.522-.523).

IV. Early Intervention Services

- Part H lists the services that must be part of an early intervention system in two ways. It describes the developmental areas with which Congress is concerned, and lists specific services that must be part of the state program (20 U.S.C. Section 1472(2)). However, the Part H regulations note that the list of services is not intended to be exhaustive (34 C.F.R. Section 303.12 (Note)).

- Congress expressed concern for developmental needs in the following areas:

  - physical development;
  - cognitive development;
  - language and speech development;
  - psychosocial development;
  - self help skills.

(20 U.S.C. Section 1472(2)(C)).

- In addition, Congress identified the following services as being likely to address those areas of need and therefore being part of an early intervention system:

  - family training, counseling and home visits;
  - special instruction;
  - speech pathology and audiology;
  - occupational therapy;
  - health services necessary to enable an infant or toddler to benefit from other early intervention services.
  - medical services only for diagnostic or evaluation purposes;
  - early identification, screening, and assessment services;
  - physical therapy;
  - psychological services;
  - case management services (20 U.S.C. Section 1472(2)(E))

A. Interagency Agreements

- Part H is premised on the assumption that there are some services currently in existence to aid infants, toddlers and their families. Part H is not based on the same findings of extreme neglect on which the EHA programs for children 3 - 21 are based. Instead, Part H assumes the greatest need is the coordination of all the existing programs that provide services to handicapped infants, toddlers, and their families, and to fill in gaps with new, Part H funds. Congress intended that the state early intervention system would be comprised of a interlocked network of Federal, state, local and private services providers. Formal interagency agreements would create the network (20 U.S.C. Section 1476(b)(9)(F); 34 C.F.R. Section 303.144; .523-.524).

- These agreements are necessary to ensure each services provider in the state system maintains its financial commitment to the child and family. Each program will continue to have its own responsibilities to provide services; Part H funds are available only to "supplement" existing resources, not "supplant" them (20 U.S.C. Section 1478(b)(5); 34 C.F.R. Section .124). In addition, Part H mandates that in relation to the funds available from every other program, its funds are to be used only as a last resort (20 U.S.C. Section 1481; 34 C.F.R. Section 303.527). Even programs like Medicaid and vocational rehabilitation, which have their own "last resort" provisions, must be tapped first, before Part H.

B. Child Find, Referral & Evaluation

* Part H requires the lead agency to create a multi-agency, statewide child find system capable of identifying all infants, toddlers and families who may be eligible for early intervention services (34 C.F.R. Section 303.164; .321). This will be similar to the effort required under the EHA program for children 3-21, but must take advantage of all the interagency resources to be coordinated by the Part H lead agency (34 C.F.R. Section 303.321(c)).

* Following identification, the child and family must be referred for evaluation and assessment of their early intervention services needs (34 C.F.R. Sections 303.321(d)). The Part H regulations assign different terms to the inquiries to be made of the child, and of the family. Children are to be "evaluated," and the family is to be "assessed." Section 303.322 details the contents of the child's evaluation and family's assessment.

* The referrals are required to be made not more than 2 working days after the child and family are identified (34 C.F.R. Section 303.321(d)(2)(ii)). Evaluations, and the meeting to develop the IFSP are required to be completed not more than 45 days after referral, if public agencies are conducting the evaluations and assessments (Section 303.321(e)).

C. Case Management Services

* Case management is an entitlement under Part H. Part H requires states to make case management services available to eligible children and families not later than the start of the fourth year of Part H funding (34 C.F.R. Section 303.341).

* Each state is responsible for establishing the procedures for selection and appointment of case managers. The Part H regulations address this issue by requiring that the case manager come from " the profession most immediately relevant to the child's or family's needs..." based on the individual and family evaluations and assessments (34 C.F.R. Section 303.344 (g)).

* A case manager will be responsible for coordinating all the services a child and family may require; to be a single point of contact between the child, family and services system. Case management is designed to be an on-going process, with contact continuing for as long as the child and family is receiving early intervention services (34 C.F.R. Section 303.6).

- The Part H regulations also set standards for the case manager. Among the qualifications for the position is knowledge of the nature and scope of services that are available from all the services providers participating in the early intervention system (34 C.F.R. Section 303.6(d)).

D. Individualized Family Service Plan ("IFSP")

- Each child and family eligible to receive early intervention services will receive an individualized family service plan ("IFSP"). The IFSP, like the IEP for children age 3-21, is the blueprint for all early intervention services to be provided to the child and family. An IFSP is an entitlement, beginning in the fourth year of the state's Part H funding; by the start of the fifth year of funding, the IFSP must be implemented in its entirety.

- The IFSP must be developed jointly by the parents, the persons who conducted the evaluations and assessments, 20 U.S.C. Section 1477(a)(2), the case manager appointed by the state lead agency, and if possible, the proposed services providers. Parents also can have an advocate present, if they so desire (34 C.F.R. Section 303.343).

- The meeting to develop the IFSP must be held within 45 calendar days of the initial referral of the child and family for evaluation and assessment (34 C.F.R. Section 303.342(a)).

- Part H and its regulations state what must be stated in an IFSP. The contents of an IFSP are somewhat similar to the contents of an IEP. There must be

(1) a statement of the infant or toddler's present levels of physical development, cognitive development, language and speech development, psycho-social development, and self help skills, based on acceptable objective criteria;
(2) a statement of the family's strengths and needs relating to enhancing the development of the family's handicapped infant or toddler;
(3) a statement of the major outcomes expected to be achieved for the infant or toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary;
(4) a statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity and method of delivering services;
(5) the projected dates for initiation of services and the anticipated duration of such services;
(6) the name of the case manager from the profession most immediately relevant to the infant or toddler's or family's needs

who will be responsible for the implementation of the plan and coordination with other agencies and persons, and

(7) the steps to be taken supporting the transition of the handicapped toddler to services provided under the [EHA program for children age 3 - 21] to the extent such services are considered appropriate (20 U.S.C. Section 1477(d)).

- A feature of the IFSP that is different from the IEP is that the parents have the authority to make the ultimate decision as to whether they will receive early intervention services, and as to which services they will receive (34 C.F.R. Section 303.344(Note)).

- IFSPs have a total possible duration of 36 months. During that period, they must be reviewed every six months (34 U.S.C. Section 1477(b)). In addition, an annual review is required (34 C.F.R. Section 303.342(c)). The frequent reviews are deemed necessary because of the rapid changes that occur in children's development. Each review allows for progress toward the IFSP "outcomes" to be measured and for strategies and services to be altered as needed (Section 303.342(b)).

V. What Makes Early Intervention An Assistive Technology Resource?

A. Introduction

- The early intervention program is both the coordinator of services provided by other sources as well as a direct provider of services. In both roles, it is an important resource for funding assistive technology devices and services.

- Congress created the early intervention program because it recognized the value these services can have in preventing and reducing the effects of handicapping conditions in children. In other legislation, i.e., the Tech Act, Congress recognized the essential role assistive technology can have in the lives of persons with handicaps and their families.

- The coordination role of the state lead agency under Part H must include bringing together these two congressional initiatives. State Tech Act staff must ensure that the Part H lead agency is aware of the important opportunities assistive technology can offer even to infants and toddlers.

- As a services coordination program, early intervention will apply the funding potential that is present in the services provided by other programs. For this reason, Tech Act staff must be familiar with the scope of other programs, particularly the state Medicaid program, to determine what assistive technology devices and services will be available.

B. General Program Criteria Supporting Funding

- The state early intervention system that results from compliance with Part H will contain many components that should be viewed as supporting assistive technology funding. Among them include:

"Early Intervention Services" "Interagency Agreements"

"Staff Development"

Each of these terms is described below.

C. General Program Criteria Perceived as Funding Barriers

- Part H contains no express barriers to funding assistive technology devices and services.

- Nonetheless, the early intervention program has many potential assistive technology funding barriers. They include the following:

"Part H Funding Levels" "Implementation Schedule for ISSPs and Services"

"A Lack of Basic Knowledge"

Each of these terms is described below.

1. Early Intervention Services

- Congress listed the services that are likely to comprise a state's early intervention system (20 U.S.C. Section 1472(2)(E); 34 C.F.R. Section 303.12). Of these, there are some services that previously have been described in the Medicaid and Special Education sections as assistive technology funding resources.

- Because so many of the early intervention system's services will be provided by the state Medicaid program, a clear understanding of its scope is essential. In addition, state Tech Act staff should become familiar with the state's Maternal and Child Health program (sometimes called the Crippled Children's program), which also may provide services to infants, toddlers and their families. Maternal and Child Health funding is provided to states through a "block grant" from the federal government. (It is not discussed in this funding manual).

a. Case Management Services

- Case management is perhaps the most important service within the early intervention services system. The person selected to be the case manager will have enormous potential to aid children and families in the design of a comprehensive and effective program of services. Among the many services children and families may require is assistive technology.

- Case managers are required by the Part H regulations to have an understanding of the infants and toddlers who are eligible for early intervention services, and the nature and scope of services under the State's early intervention system (34 C.F.R.

Section 303.6(d); .12(d)(2)).

* Because so much of the early intervention system will be provided by other agencies, case managers must be aware of the extraordinary scope of programs such as Medicaid. With such knowledge, case managers can plan assistive technology services with families and assist in the advocacy tasks that will be necessary to secure funding. By contrast, case managers who are not aware of the importance of assistive technology, and of the sources of available funding will not be able to meet the true promise of Part H.

* State Tech Act staff can play an important role by ensuring that case managers receive training on both the potential of assistive technology and its funding. Coordination of case manager training can be achieved by agreements between the Tech Act staff and the state early intervention lead agency.

b. Nursing Services

* The Part H regulations state that nursing services includes

(i) the assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;
(ii) provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and
(iii) administration of medications, treatments and regimens prescribed by a licensed physician (34 C.F.R. Section 303.12(d)(6)).

* Nursing services are an important assistive technology service. State "nurse practice" laws and rules often mandate that certain services be provided by either Registered or Licensed Practical Nurses. This includes services to "technology dependent children" who require ventilators, IVs, and/or tube feeding. For these children and others in similar circumstances, nurses will be a regular part of their lives.

* Nursing services have been a matter of significant controversy because there has been no agreement as to how "regular" the "lives" of technology dependent children and others will be. For example, they have been controversial in the EHA programs for children age 3-21, and in the Medicaid program because schools do not want to provide sophisticated health services, and because Medicaid has attempted to deny nurses access to school, or anywhere other than the child's home.

* The EHA limitation will not be relevant to infants and toddlers because they will not be attending pre-school or school programs. Those begin at age 3 and 5, respectively.

* The Medicaid "at home" limitation, by contrast, will be an important concern

in the Part H program. One conflict is Medicaid's "at home" restriction for nurses, and the definition of "locations" in the Part H regulations (34 C.F.R. Section 303.12 (b)). The Part H rules state that early intervention services are to be provided

> in the type of settings in which infants and toddlers without handicaps would participate.

It is obvious that children without handicaps are not limited to their homes, or to any other location. It is not clear whether the Part H rules or the Medicaid restriction would take precedence in relation to the scope of nursing services available to infants and toddlers.[31]

* Tech Act staff can work with state Medicaid directors, and the Part H lead agency to clarify the state's position in regard to these "at home" restrictions. To date, advocates for children have made few efforts to eliminate the "at home" restrictions. Despite the lawsuits and recent proposed policy changes, clearly more can and must be done.

c. Occupational Therapy

* The Part H regulations for occupational therapy expressly state that assistive technology is included within its scope. The regulations define this service as follows:

> services to address the functional needs of a child related to the performance of self help skills, adaptive behavior and play, and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include --
>
> (i) identification, assessment, and intervention;
> (ii) adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
> (iii) prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

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[31] The Medicaid "at home" restrictions on nurses, both private duty nurses, and nurses provided through home health services currently are being challenged in court. In February 1990, the federal court of appeals in New York called the "at home" restriction arbitrary and unreasonable, and set it aside. the Court ruled that nurses must be able to go with recipients to any normal life activity whether in or out of the recipient's home. That decision affected Connecticut, New York and Vermont. *Detsel v. Sullivan*, 895 F.2d 58 (2d Cir. 1990). Most recently, in response to a proposed nationwide class action, the federal government proposed to eliminate the "at home" restriction on private duty nursing throughout the country. *Pullen v. Cuomo*.

Medicaid also has imposed an "at home" restriction on nursing provided as a "home health" service. This restriction is being challenged in *Skubel v. Sullivan*, which has been brought as a nationwide class action, and currently is pending in the U.S. District Court in Connecticut.

* The regulation clearly states that assistive technology is to be part of the early intervention occupational therapy service. The significance of this definition is that the state lead agency must ensure that the state Medicaid and other existing services programs that provide occupational therapy do so in a manner consistent with this definition.

d. Physical Therapy

* The Part H regulations define physical therapy to include:

(i) screening of infants and toddlers to identify movement dysfunction;
(ii) obtaining, interpreting, and integrating information appropriate to program planning, to prevent or alleviate movement dysfunction and related functional problems, and
(iii) providing services to prevent or alleviate movement dysfunction and related functional problems (34 C.F.R. Section 303.12(d)(9)).

* The regulation makes assistive technology a part of physical therapy. Services are to be provided to "alleviate" movement dysfunction. Many different types of assistive technology can accomplish this goal.

* State Tech Act staff can serve an important role to ensure all the participants in the state early intervention program understand the scope of the physical therapy service. Unlike occupational therapy, there is no express reference to assistive technology in the rules. But by working with the Part H lead agency, state Tech Act staff can help develop interagency agreements that state expressly that assistive technology is to be a part of the physical therapy service.

* For example, as stated elsewhere in this funding manual, Medicaid will fund assistive technology through its physical therapy service, either through the Medicaid EPSDT service (which applies to children less than age 21), or simply as a part of the state medical assistance plan. It is possible, however, that the state Medicaid agency will not recognize the potential for its physical therapy service to fund assistive technology. But, an interagency agreement between the state Medicaid and Part H lead agencies that states clearly that assistive technology will be available to infants and toddlers through the Medicaid physical therapy service can have a dual effect of clarifying the scope of the Medicaid services, and extending an important assistive technology service to recipients of early intervention.

e. Special Instruction

* The Part H regulations define "special instruction" as

(i) the design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;

(ii) curriculum planning, including the planned interaction of personnel, materials, and time and space, that lead to achieving the outcomes in the child's [IFSP];

(iii) providing families with information, skills, and support related to enhancing the skill development of the child, and

(iv) working with the child to enhance the child's development (34 C.F.R. Section 303.12(d)(12)).

* The definition of special instruction should be viewed as offering the same assistive technology opportunities as "special education" in the EHA program for children age 3-21. As noted in that discussion, computers and other learning aids can be an appropriate means of providing instruction to children with handicaps, and both the hardware and programs will have to be provided as part of the child's "special education". Yet there is no minimum age at which a child becomes "ready" to use assistive technology. They can be as integral a part of the development of infants and toddlers with handicaps as they are for the instruction of older children. No barrier exists to having it be considered special instruction under Part H.

* State Tech Act staff have an important role to perform in relation to the early intervention "special instruction" service. They must work with the Part H lead agency to identify the existing services program that will serve as the vehicle to deliver "special instruction". Although schools may be asked to assist in providing these services, the EHA will not serve as the funding source: its scope is children age 3-21.

* State Tech Act staff will have to be creative to identify the source(s) of special instruction funding. Among the agencies to inquire with include the state Maternal & Child Health program, the state "Head Start" program, Medicaid services for new mothers, existing infant stimulation programs, mental retardation and developmental disabilities programs, etc.

* One caveat: providing "instruction" to infants and toddlers may not be within the range of services provided by any existing program. To the extent special instruction involves costs, such as for devices, equipment, or staff, Part H funds may be required to provide this service directly.

f. Speech Pathology & Audiology

* The Part H regulations define audiology to include:

(i) identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques;

(ii) determination of the range, nature and degree of hearing loss and communication functions, by use of audiological evaluation procedures;

(iii) referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;
(iv) provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;
(v) provision of services for prevention of hearing loss; and
(vi) determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices (34 C.F.R. Section 303.12(d)(1)).

- Speech pathology is defined by the Part H regulations to include:

(i) identification of children with communicative or oral pharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
(ii) referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oral pharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills.
(iii) provision of services for the habilitation, rehabilitation, or prevention of communicative or oral pharyngeal disorders and delays in development of communication skills.

- Speech pathology and audiology are clearly possible sources of assistive technology through the early intervention program. The audiology regulations clearly state that the provision of devices is included; the speech pathology regulations speak only of services, but as is discussed in the Medicaid and special education sections, that term should be read to include augmentative communication devices.

2. Staff Development

- Part H, like the EHA program for children age 3-21, require the states to undertake a comprehensive system of staff development (20 U.S.C. Section 1476(b)(8)). The purpose for this requirement is to ensure that infants and toddlers with handicaps, and their families, have access to skilled personnel who are able to provide the early intervention services to meet their needs.

- The Part H regulations permit states to incorporate the staff development procedures used for the other EHA program, or to devise a separate program for early intervention (34 C.F.R. Section 303.167; .360).

- Pre-service and in-service training in regard to assistive technology is an important staff development effort. Already discussed is the role State Tech Act staff can perform in relation to the training of case managers. Yet this training is equally important for all other early intervention staff. Case technology to aid individuals with handicaps, how to conduct proper evaluations, how to assist in the selection and "fit" of appropriate devices and services, and how to conduct follow up to ensure the children are using the devices and services to their full potential.

- State Tech Act staff have an important role here. If they are successful in integrating assistive technology for children before school, then their efforts to educate school district and state education department staff will lead to the smooth transition of these children into pre-school programs at age 3. Such transitional planning is a separate requirement of the early intervention system (34 C.F.R. 303.344(h)).

3. Interagency Agreements

- As the states develop the various components of the early intervention system, they are expected to enter into formal interagency agreements with other state agencies (20 U.S.C. Section 1476(b)(9)(F); 34 C.F.R. Section 303.523).

- These agreements are an essential tool for assistive technology to become a part of the early intervention program. State Tech Act staff must educate lead agency staff about the potential of assistive technology, and of the proper interpretation of the various programs that will fund assistive technology, such as Medicaid.

- The importance of the agreements is that they are expected to outline the financial responsibility of each agency to meet the demands of the early intervention system. For a program of the dimensions of Medicaid, the lead agency and Tech Act staff together could resolve questions in regard to the medical need for assistive technology as a matter of policy, thus making it infinitely easier for individuals to be approved for these devices and services.

- On the other hand, if no agreement as to policy is possible, individuals still have the ability to fight for these devices and services on their own. Moreover, none of the other state programs are able to redefine the scope of their programs more narrowly because of the Part H program (34 C.F.R. Section 303.527(c)).

4. Part H Funding Levels

- For early intervention to meet the promise stated in the law and regulations, adequate funding must be made available. Less than adequate funding may be a severe barrier to having the early intervention program be one of great promise in regard to assistive technology.

- In fiscal year 1989, the total national appropriation for Part H is less than $80 million. (A list of state by state appropriations is annexed). The current funding for Part H is still planning and development. As planning is transformed into direct services

Early Intervention Program for Handicapped Infants & Toddlers

State Lead Agencies

State	Estimated 1990 Appropriation	State	Estimated 1990 Appropriation
Alabama	172,958	Massachusetts	1,639,476
Alaska	388,764	Michigan	2,739,123
Arizona	1,232,939	Minnesota	1,299,584
Arkansas	686,447	Mississippi	813,073
California	9,756,876	Missouri	1,479,526
Colorado	1,059,661	Montana	388,764
Connecticut	906,377	Nebraska	473,182
Delaware	388,764	Nevada	388,764
DC	388,764	New Hampshire	388,764
Florida	3,452,229	New Jersey	2,179,303
Georgia	2,012,689	New Mexico	533,163
Hawaii	388,764	New York	5,224,994
Idaho	388,764	North Carolina	1,826,082
Illinois	3,458,893	North Dakota	388,764
Indiana	1,552,836	Ohio	3,105,673
Iowa	746,428	Oklahoma	959,693
Kansas	766,422	Oregon	753,092
Kentucky	1,006,345	Pennsylvania	3,185,647
Louisiana	1,459,533	Rhode Island	388,764
Maine	388,764	South Carolina	1,039,668
Maryland	1,412,881	South Dakota	388,764

Tennessee	1,332,907
Texas	5,951,428
Utah	699,776
Vermont	388.764
Virginia	1,746,108
Washington	1,399,552
West Virginia	446,524
Wisconsin	1,419,546
Wyoming	388,764
USA TOTAL	$ 79.520,000

Source: Early Childhood Reporter, Vol. 1, Issue 3, at p. 9 (Mar. 1990).

activities, there will be a need for additional appropriations to fund those early intervention services that are not part of any existing programs.

* State Tech Act staff can perform an essential role by educating the state early intervention lead agency, other services provider agencies, and state governors and legislators that assistive technology is an important component of early intervention, and that adequate sources of funding must be available to make those services available to infants and toddlers. It is not material whether the funding is made available by funding for direct services through Part H, or by increasing or redirecting the funding provided through other programs. The sole criterion for acquisition and use of assistive technology.

5. A Lack of Basic Knowledge

* The last barrier to successfully integrating assistive technology into the lives of infants and toddlers with handicaps has been addressed throughout this funding manual: the lack of general information about the potential value of assistive technology throughout state government, and throughout the general population.

* State Tech Act staff must take every opportunity to promote the potential of assistive technology to government leaders, program staff, professionals serving infants and toddlers with handicaps, and parents.

6. Implementation Schedule for IFSPs and Services

* The Part H regulations provide a schedule for states to develop their early intervention programs. Two steps of that progression: the duty of the states to develop IFSPs in year four, a full year before the services stated in the IFSPs have to be implemented (in year five), is a potential barrier to the success of the early intervention program in general.

* No rationale was offered to support the bifurcation of these two steps. The evaluations on which IFSPs are based will demonstrate immediate needs for services, yet they may not be provided for a year. This delay raises the potential for parents to become disenchanted with the early intervention program as a set of promises for which there is no delivery.

* This barrier is written into the Part H regulations, but is not required to cause this potential adverse effect. State lead agencies, with the counsel of State Tech Act staff, can work to ensure that as many services as possible that are identified and incorporated on IFSPs are provided immediately to infants, toddlers and their families, rather than in year five. This may be part of the interagency agreement process, or a separate effort involving the various agencies, the state governor, and/or legislature.

Part C. Section 504 Of The Rehabilitation Act

I. Introduction

* Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, is a civil rights statute that prohibits "discrimination" against persons with handicaps.

* Section 504 is an extremely important, yet poorly understood law in relation to children with handicaps in school. Section 504 most often is overlooked because the attention and primary reliance is given to the EHA. However, Section 504 both complements and supplements the EHA. At times the two laws overlap and their coverage/protections are redundant. However, Section 504 also provides some protections that the EHA does not.

* Even though Section 504 does not provide any direct funding, it is an important resource in regard to securing assistive technology to aid handicapped children in school.

II. Who Is Protected By Section 504?

A. Text of the Law and Regulations

* Section 504 was enacted to extend to discrimination on the basis of handicap the prohibition that previously had been stated for gender, national origin, race and religion.

* Section 504 is only one sentence long:

> No otherwise qualified handicapped individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance...(29 U.S.C. Section 794).

1. "Handicapped Individual"

* The Rehabilitation Act states the definition of "handicapped individual." To be "handicapped" an individual must have

(i) a physical or mental impairment which substantially limits one or more of such person's major life activities;
(ii) a record of such impairment; or
(iii) is regarded as having such an impairment (29 U.S.C. Section 706(7)).

* Regulations add definitions to these terms. The U.S. Department of Education Section 504 regulations are stated at 34 C.F.R. Section 104. The rules apply to all programs funded by the Department of Education, including the three EHA programs (Section 104.2).

- The Section 504 definition of "handicapped individual" is based on the presence of two characteristics: (1) a physical or mental impairment," and (2) the substantial limitation of "major life activities." The term "physical or mental impairment" includes:

  (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive, genito-urinary; hermic and lymphatic; skin; and endocrine; or
  (B) any mental or physiological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities (34 C.F.R. Section 104.3(j)(2)(i); 104.3(l)).

2. "Major Life Activities"

- The term "major life activities" is defined as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

3. Protections Against Prejudice Related To Perceived Impairments

- In addition to impairments that actually cause limits to major life activities, the Section 504 regulations ensure that protections are extended for prejudice and misperception.

- Section 504 protects persons who currently have a physical or mental impairment, those who have a history of, or even a misclassification of an impairment, as well as those who are regarded by others (correctly or mistakenly) as having an impairment. The "regarded as having" criterion is extremely broad. It includes any person who

  (A) has a physical or mental impairment that does not substantially limit major life activities but who is treated as constituting such a limitation;
  (B) has a physical or mental impairment that substantially limits major life activities only as a result of attitudes of others toward such impairment; or
  (C) has none of the impairments defined in para. (j)(2)(i), but is treated as having such an impairment.

4. "Qualified Handicapped Individual"

- Another Section 504 criterion is that it protects "qualified" handicapped individuals. "Qualified" is defined in the Section 504 regulations in relation to employment, education and other services. With regard to primary and secondary education, it covers any person:

(i) of an age during which nonhandicapped persons are provided educational services;
(ii) of an age during which it is mandatory under state law to provide such services to handicapped persons; or
(iii) to whom a state is required to provide a FAPE under the EHA (34 C.F.R. Section 104.3(k)).

5. Prohibited Discriminatory Actions

* Finally, a comprehensive definition is supplied for "discriminatory actions" that are prohibited by Section 504.

The definition is stated in six parts. The first two sections are stated below:

(1) A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:
(i) deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit or service;
(ii) afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded to others;
(iii) provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;
(iv) provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide [them] with aids, benefits or services that are as effective as those provided to others;
(v) aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit or service to beneficiaries of the recipient's program;
(vii) otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

(2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs (34 C.F.R. Section 104.4(b)).

6. Recent Amendments Strengthening Section 504 Protections

* Throughout the 1980s, the Supreme Court and Congress have differed on the scope and proper interpretation of both the EHA and Section 504. This has led to three amendments which were enacted to overturn Supreme Court decisions affecting Section 504. In addition, the pending reauthorization of the EHA contains an amendment to overturn a fourth Supreme Court decision that limited the scope of the EHA.

* In the EHA Amendments of 1986, Congress restated that children with handicaps could use the protections/rights afforded by **both** the EHA and Section 504 (See 20 U.S.C. Section 1415(f)). This amendment was necessary to overturn an earlier Supreme Court decision that concluded the EHA provided an exclusive remedy for children with handicaps.

* In another statute, the *Civil Rights Restoration Act*, Congress makes clear that if any federal financial assistance is received, the entire entity, i.e., school district or state education department, must abide by Section 504. The CRRA overturned a second Supreme Court decision that would have limited the scope of Section 504 coverage to the specific department or program that received the federal financial assistance.

* In a third statute, the *Rehabilitation Act Amendments of 1986*, Congress makes clear that states, like any other recipient of federal financial assistance, is subject to federal court suit for violation of Section 504 (See 42 U.S.C. Section 2000d-7(a)(l)). This amendment overruled yet another Supreme Court decision which held that states receiving federal financial assistance did not waive their protections from being sued in federal court. The protection from federal court suits are provided by the Eleventh Amendment to the U.S. Constitution. The Court concluded that a state could not be sued under Section 504 in federal court.

* In the presently pending EHA reauthorization, Congress is proposing to make clear that states receiving EHA funds expressly waive their Eleventh Amendment immunity, and thus are subject to suits in federal court for violations of that Act. If enacted, this amendment would overturn a fourth Supreme Court decision that held the EHA procedural protections provisions are not specific enough to constitute a waiver of the state's Eleventh Amendment protections.

B. Comparison of Section 504 and the EHA

* Both the EHA and Section 504 create rights to a Free Appropriate Public Education, an individualized education plan, procedural safeguards, and least restrictive environment. As noted above, the overlaps between the EHA and Section 504 regulations are extensive.

* However, Section 504 has three important differences from the EHA.

1. Definition of "Handicap"

* The EHA limits the definition of handicap to 11 conditions stated in the Act. Section 504 does not. Section 504 will include all 11 EHA conditions, but will cover many more. The Section 504 definition of handicap will embrace any physical or mental impairment, a far broader definition than is contained in the EHA.

* Not only does the EHA limit its coverage to listed conditions, the EHA also requires there to be joinder between the existence of the condition and the need for special education. Section 504 does not: it has no such requirement. Rather, Section 504 requires that the impairment affect a major life activity, which has no direct connection to special education.

* Section 504 will cover children who are temporarily handicapped, assuming it is severe enough, and long-lasting enough to require special education or related services.

2. Definition of "Appropriate" Education

* The EHA states that a handicapped child is one who requires special education and related services. The presence of the word "and" has the effect of excluding some children from coverage under the EHA.

* Those children, however, cannot be denied a Free Appropriate Public Education. As long as they have a handicapping condition, and need special education or related services, they are entitled to have their needs met pursuant to Section 504.

* The Section 504 regulations expressly state that handicapped children are entitled to a Free Appropriate Public Education through Section 504. In addition, Section 504 will permit their needs to be met regardless whether they need special education and related services. As long as they need one or the other, they are covered.

* The Section 504 regulations, 34 C.F.R. Section 104.33(b)(1), define "appropriate education" as follows:

> (1) the provision of an appropriate education is the provision of regular or special education and related aids and services that (i) are designed to meet the individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met;
> ...

* The Section 504 regulations focus on the child's "needs," as well as the "adequacy" of the program in comparison to the programs offered to others. Section 504 has at its heart an ongoing comparison between the programs, services and opportunities offered to children with handicaps, and those that are offered to nonhandicapped children.

3. There Is No Requirement That Related Aids And Services Are Needed For The Child To "Benefit" From Special Education"

- The EHA states that unless a related service is needed to allow the handicapped child to benefit from his/her special education, then the service is not covered by the Act. Section 504 is different.

- Section 504 makes no demand that a child even need special education. For this reason, related aids and services do not have to allow the child to "benefit" from special education.

- Rather, the proof must establish that the service is needed to enable the child to have an educational program that is equally effective as that offered to other children.

III. What Makes Section 504 A Resource For Assistive Technology Funding?

- Section 504 does not provide funding. It is a civil rights statute that requires equal access and equal opportunity to persons with handicaps.

- In regard to assistive technology, Section 504 will make more children eligible for a FAPE than are covered by the EHA. By this means alone, any assistive technology available to children under the EHA also is available to all children protected by Section 504.

- In addition, Section 504 will allow a child to receive assistive technology regardless whether it is needed to allow the child to benefit from special education. This substantially expands the scope of possible assistive technology integration in the schools.

- Section 504 also incorporates all the EHA concepts in relation to FAPE. Section 504 will prohibit a school district from insisting that parents use their insurance proceeds to pay for related aids and services. It also will prohibit a school district from forcing parents to sign a liability waiver before any service is provided to their child, or before their child is allowed in school.

- Section 504 will prohibit schools from denying children the opportunity to take home assistive technology devices if those devices are needed to enable those children to have an equal opportunity to participate in school. If a child receives instruction by computer, or if a quadriplegic child uses a computer as a notebook, and other children receive homework, then the child should be provided access to a computer at home, either by having a portable computer available, or by providing a second one. Also, just as children are expected to use their vocabulary skills, and to practice their lessons at home, so too must the child who uses an augmentative communication device be allowed to take it home.

SECTION III

OUTLINE OF VOCATIONAL REHABILITATION PROGRAMS

- Vocational Rehabilitation ("VR") is a group of programs that will assist individuals with disabilities increase the level of their productive activities. Because disabilities span an infinite range of severity, VR programs will assist individuals who can be employed competitively, or in supported or sheltered employment, as well as those whose goal is to have greater independence in their community living opportunities. Based on this range of services opportunities, it is hard to imagine how an individual could be found ineligible for any VR services.

- Congress has stated that the purposes of VR programs are to "maximize [individuals with disabilities'] employability, independence and integration into the workplace and the community." These goals are to be achieved through "research, training, services, the guarantee of equal opportunity, and comprehensive and coordinated programs of vocational rehabilitation and independent living" (29 U.S.C. Section 701).

- Federal government support for VR services dates back more than 70 years. Publicly funded vocational rehabilitation came into being after World War I, and has been the subject of legislation in every subsequent decade. More recently, VR programs have been profoundly affected by the emergence of a civil rights movement for persons with disabilities. In 1973, 1978, 1986, and in 1990, with the enactment of the Americans with Disabilities Act, the scope of vocational rehabilitation services, and/or the civil rights and protections afforded to persons with handicaps have greatly expanded. The ultimate goals, however, have remained consistent throughout all these legislative amendments:

> to assure that all individuals with handicaps are able to live their lives independently and with dignity, and that the complete integration of all individuals with handicaps into normal community living, working and service patterns be held as the final objective...(Public Law No. 93-516, Section 301(6)).

- VR programs are model programs with regard to assistive technology funding. VR programs are the only federal funding programs that require an evaluation for assistive technology as a routine part of the determination of services eligibility. They also state repeatedly that assistive technology is one of the services for which funding is provided.

- The "assimilation" of assistive technology into the various VR programs, i.e., the routine consideration whether the applicant for services has the potential to benefit from assistive technology, should be the goal for all federal funding programs for persons with disabilities.

* Four VR programs are discussed here. They are found in four subparts of the federal Rehabilitation Act, 29 U.S.C. Sections 701 - 796. They include:

> Vocational Rehabilitation Services (also known as Title I), 29 U.S.C. Sections 720 -732;
>
> Projects with Industry, 29 U.S.C. Section 795g;
>
> Supported Employment for Individuals With Severe Handicaps (a.k.a. Title VI or Part C), 29 U.S.C. Section 795j - 795q;
>
> Comprehensive Services for Independent Living (a.k.a. Title VII or Part A), 29 U.S.C. Section 796a- 796d;
>
> Federal regulations applicable to each of these programs can be found at 34 C.F.R. Parts 361 - end.

* Like Medicaid and special education, three of these VR programs are examples of "cooperative federalism," in which the federal and state (or federal, state and local) governments share responsibilities for providing benefits, and for which a state plan is a prerequisite (vocational rehabilitation, supported employment, and independent living services). In addition, VR programs include a grants program for which project applications are reviewed individually against eligibility criteria stated in the federal regulations (projects with industry).

* VR programs can provide direct services, as well as cash grants for the purchase of both services and equipment.

Part A. Title I Vocational Rehabilitation Services

I. INTRODUCTION

* The origins of vocational rehabilitation services date back more than 60 years. VR programs have been viewed as a means to legislate both good will and common sense. VR has focused on the potential for recipients, regardless of financial status, to enter, remain or return to the competitive economy. The underlying assumption is that by providing temporary assistance to individuals with the potential to be competitively employed, there will be a greater return to the economy through their employment and greater productivity. In 1986, Congress estimated the return as greater than ten dollars for each one dollar of VR services provided.

* In 1974, Congress estimated there were 7 million children and at least 28 million adults who have mental and physical handicaps and who may be able to benefit from vocational rehabilitation services.

- The key concept of the Title I VR program is employability. Federal funding for Title I is provided to enable individuals with handicaps to prepare for and engage in gainful employment to the extent of their capabilities (29 U.S.C. Section 720(a)).

- The Title I VR program provides cash grants to individuals as well as funding for the purchase of services and equipment.

II. STATE PLAN REQUIREMENTS

- To receive federal financial assistance through Title I, which totaled $ 1.5 billion in FY 1989, states must submit a comprehensive rehabilitation services plan every three years (29 U.S.C. Section 721(a)). The Act permits the consolidation of the VR services plan with state plans required under other statutes, such as the Developmental Disabilities Assistance and Bill of Rights Act.

- The state plan must establish that the state legislature has conveyed state statutory authority to a lead agency to carry out the details of the plan (34 C.F.R. Section 361.5(d)). It must identify the single state agency to administer the Title I VR program, except that a separate agency may be authorized to administer programs for the blind and visually impaired (Section 721(a)(1)(A)).

- States must assure that they will meet their financial commitment, which now equals 25% of the cost of covered services (Section 706(7); 721(a)(3)). States are further authorized to divide their share with local governments (Section 706(7)(D)). The federal share of expenditures has decreased since 1988. Prior to that date, the federal share of VR expenditures was 80%.

- States must assure that the Title I VR program will be in effect statewide, and describe how the plan will be implemented: the plans, policies and methods of administration of the program must be described (Section 721(a)(4); (a)(5)). The states must describe their efforts to make a state-wide, comprehensive needs assessment of rehabilitation needs among its citizens with severe handicaps and how they will expand and improve services (Section 721(a)(5)). [22]

- The state plan must describe an "order of selection," which is a description of the policies and procedures to be employed if VR services must be rationed because of insufficient funds. The Rehabilitation Act states that the first priority for services must be for persons with the most severe handicaps (Section 721(a)(5)). [33]

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[22] The Act authorizes a "waiver" to the statewideness requirement. The state may request a waiver to allow it to serve a larger number of individuals with a particular type of handicap (34 C.F.R. Section 361.12(a)).

- The state plan must describe the VR services that will be provided. The Rehabilitation Act lists the services that must be provided (Section 723). The Act states that its list is not exhaustive. [34]

- The state plan must describe how the state will make use of "similar benefits," i.e., alternate funding sources for VR services (Section 721(a)(8)). The Act also requires the state to seek agreements with other state and/or federal agencies that provide financial assistance or programs for persons with handicaps (Section 721(a)(11)).

- The state plan must assure that an individualized written rehabilitation plan (IWRP) is developed for each individual with handicaps who seeks VR services (Section 721(a)(9)).

- The Act also requires the states to provide ongoing staff development, 34 C.F.R. Section 361.16. This is an important criterion, also present in special education programs, based on the continuing, rapid evolution of rehabilitation techniques and methods.

- The Act also requires the state plans to address "rehabilitation engineering." The state plan must explain how the state will increase the number of individuals with handicaps who will be assisted by rehabilitation engineering, Section 721(a)(5)(C); 34 C.F.R. Section 361.2(b). This is the only specific vocational rehabilitation service that the state plan must specifically address.

III. INDIVIDUAL ELIGIBILITY CRITERIA

A. Introduction

- The eligibility criteria for Title I VR services are very liberal. In general, any individual with a handicap who is present in the state, and who can demonstrate a reasonable expectation that VR services will benefit his or her employability will be eligible for Title I VR services. Each of the component parts of this statement are described further below.

- Although that general eligibility statement is very broad, Title I VR services do not operate through a "zero reject" policy. Nonetheless, the system discourages rejection for services by imposing numerous prerequisites. [35]

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[33] This is a characteristic unique to VR services among the programs described in this outline. By contrast, insufficient funding is not a legitimate basis to deny services under either Medicaid or EHA supported programs.

[34] The Rehabilitation Act list of services can be contrasted with both the Medicaid Act and the EHA. Unlike Medicaid, in which the program includes both mandatory and optional elements, all the services included in the Rehabilitation Act are mandatory. No "optional" services are identified, although the Act expressly authorizes others to be provided. In this regard, the Rehabilitation Act list is more similar to the list of related services stated in the EHA.

* The Act creates two sets of eligibility criteria. First, there are criteria applicable to the Title I VR services program in general. Second, there is a requirement that an "order of selection" be stated, for times when demand for services is estimated to exceed available financial resources.

* Eligibility criteria cannot categorically exclude persons based on age, or type of handicapping condition (34 C.F.R. Section 361.31(a)).

1. Financial Need Determinations

* The Act permits a person's finances to be considered in both sets of Title I VR services eligibility decisions. There are no federal criteria applicable to financial need (34 C.F.R. Section 361.47(a)(1)). However, the states are free to impose financial need criteria. To do so, they must be in writing, included in the state plan, and must specify which services will be exempt from financial need considerations (*Id*).

* The federal rules require that no financial needs test be used to provide evaluation of rehabilitation potential, counseling or placement services under Title I (34 C.F.R. Section 361.47(a)(3)). For all other VR services the state VR agency may examine whether the person has the resources to pay for some or all of the cost of the services being considered.

a. Similar Benefits

* The Act acknowledges that some applicants for services may be eligible for other services and benefits programs in addition to the Title I VR services program. These benefits and services programs also may provide similar coverage to the Title I program.

* As a means of conserving scarce Title I resources, the program includes consideration of "similar benefits," i.e., whether the person is eligible for any other program that may pay for some of the required services. One caveat: the federal rules restrict the consideration of similar benefits for six VR services:

(i) evaluation of rehabilitation potential;
(ii) counseling or guidance services;
(iii) vocational training services;
(iv) placement;

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[35] Prior to issuing a rejection, a person may be considered for a period of "extended evaluation" in which VR services are provided for up to 18 months, and during which a determination will be made whether the person will "benefit" from ongoing VR services (34 C.F.R. Section 361.34). The regulations also require that there be "clear evidence" that the person will not "benefit" in terms of employability (*Id*). Another limitation is that the grounds for a rejection must be stated in writing, and all such rejections must be reviewed not less than once per year to determine if eligibility can be established upon re-review (34 C.F.R. Sections 361.35; 361.40(d)). Finally, even if a person is found ineligible for Title I VR services, the person must be referred to the independent living rehabilitation program under 34 C.F.R. Part 363 (34 C.F.R. Section 361.34).

(v) rehabilitation engineering; and
(vi) post-employment services (29 U.S.C. Section 721(a)(8); 34 C.F.R. Section 361.47(b)). [36]

2. Individual With Handicaps

* The Act defines an "individual with handicaps" and "individual with severe handicaps" (29 U.S.C. Section 706(8); 706(15)).

> An individual with handicaps means any individual who (i) has a physical or mental disability which for such individual constitutes or results in an substantial handicap to employment and (ii) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services ....
>
> An individual with severe handicaps means an individual with handicaps, as defined in 706(8) (i) who has a severe physical or mental disability which seriously limits one or more functional capacities (such as mobility, communication, self-care, self- direction, interpersonal skills, work tolerance, or work skills) in terms of employability; (ii) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; . . . .

a. Physical or Mental Disability

* The Title I regulations define "physical or mental disability" in the broadest of terms:

> a physical or mental condition which materially limits, contributes to limiting, or if not corrected, will probably result in limiting an individual's employment activities or vocational functioning (34 C.F.R. Section 361.1).

* In addition, the definition of "severe handicaps" includes a long list of conditions that are examples of the physical or mental conditions which, if present, will

likely lead to eligibility for Title I VR services (See 29 U.S.C. Section 706(15)(A)(iii)).

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[36] There is no universally accepted procedure for conducting the similar benefits analysis. One view is to look at the specific service being requested, and to whether the individual is eligible to receive that service from any other agency. Under this procedure, Title I VR services and Medicaid can be seen to have an enormous overlap. However, such a comparison also raises the question of which of the two agencies, each claiming to be the "last resort" for funding, is responsible to provide services.

Another view, accepted by some courts, is to narrowly interpret Sections 721(a)(8) and (a)(12), which speak of "similar benefits" and "any other appropriate resource in the community," to apply only to other vocational rehabilitation programs. Thus, an initial examination is required of whether the person is eligible for any other vocational rehabilitation program. If yes, then that program is examined to determine whether it will provide the needed service. If no, then there are no similar benefits.

Under this view, the availability of the service, per se, is not material. For example, a college student with a hearing impairment may be entitled to a sign language interpreter through the college's obligations under Section 504. But the college provides an educational, not a vocational rehabilitation program. Thus, there are no similar benefits.

b. Substantial Handicap to Employment

* The Title I regulations define this part of the definition as follows:

> a physical or mental disability (in light of attendant medical, psychological, vocational, educational and other related factors) [that] impedes an individual's occupational performance, by preventing the obtaining, retaining, or preparing for employment consistent with the individual's capacities and abilities (34 C.F.R. Section 361.1).

c. Reasonably Expected To Benefit In Terms Of Employability

* There is no definition of the phrase "reasonably expected to benefit" in the Act or rules. This phrase, coupled with the opportunity for VR services to be provided during an "extended evaluation," 34 C.F.R. Section 361.34, should make it a rare case that an applicant is rejected outright for Title I VR services.

* In addition, the regulations state that before a person can be declared ineligible for Title I VR services, there must be "clear evidence" that the person is ineligible for services (34 C.F.R. Section 361.35(c)).

* Employability means a determination that "with the provision of vocational rehabilitation services, the individual is likely to enter or retain, as a primary objective, . . . employment. . . ."

* The definition continues, stating that the employment can be any of the following:

full time or part time, competitive work

the practice of a profession

self employment

homemaking

farm or family work

sheltered employment

home based employment

supported employment

other gainful work.

34 C.F.R. Section 361.1.

d. Vocational Rehabilitation Services

* The term vocational rehabilitation services is defined in the regulations to include any of the services listed in Section IV, below (34 C.F.R. Section 361.1).

3. Present In The State

* Under either the general eligibility rules, or during the "order of selection," residence requirements cannot be imposed as an eligibility pre-requisite (Section 721(a)(14)). Presence in the state is sufficient (34 C.F.R. Section 361.31(a)).

4. Demonstrate A Reasonable Expectation . . . .

* Applicants for Title I VR services must be evaluated to determine their rehabilitation potential. This process begins with a medical evaluation to determine the presence of a mental or physical disability that constitutes a substantial handicap to employability (34 C.F.R. Section 361.32).

* A second evaluation is made of applicants' vocational rehabilitation potential. This study is of medical, psychological, vocational, educational, recreational, and other factors relating to applicants' handicaps to employment and rehabilitation needs. The goal of these inquiries is to determine the nature and scope of services needed.

* A requirement of these studies is whether applicants require rehabilitation engineering services (34 C.F.R. Section 361.33).

* In some cases, predictive diagnostic or other studies will not provide sufficient information to determine whether an applicant is eligible for Title I VR services. In such cases, the applicant may be provided up to 18 months of services as an "extended evaluation" to determine rehabilitation potential (34 C.F.R. Section 361.34).

IV. SERVICES

A. Vocational Rehabilitation Services

* The federal regulations set forth a list of 16 services that states must make available to persons found eligible for VR services. The person is entitled to receive any or all of these services based on his/her individual needs. The list is not exhaustive. It includes:

Evaluation services for vocational potential, including diagnostic and related services incidental to the determination of eligibility for, and the nature and scope of services to be provided;

Counseling and guidance, including personal adjustment counseling, referral necessary to help recipients secure needed services

Reader services, note taking services & other services for persons with visual impairments;

Telecommunications, sensory & other technological aids & devices;

Physical & mental restoration services necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive. (These services are described below.)

Vocational & other training services, including personal adjustment, books, tools, and other training materials, including training and training services in institutions of higher education, so long as maximum efforts are made to secure funding from other sources;

Maintenance payments for the costs of subsistence, during the period of VR services both pre- and post-employment;

Transportation expenses, to enable the person to receive the full benefit of the other VR services being provided;

Services to family members when necessary for the vocational rehabilitation of the individual;

Interpreter services and other services for persons who are hearing impaired;

Recruitment & training services to expand employment potential in rehabilitation, health, welfare, & public service positions;

Placement services;

Post employment services necessary to maintain or regain other suitable employment;

Occupational licenses, tools, equipment, initial stocks & supplies related to an occupation or small business;

Rehabilitation engineering services;

Other goods & services that can reasonably be expected to benefit an individual with handicaps in terms of employability.

29 U.S.C. Sections 706(15); 723(a); 34 C.F.R. Sections 361.1;361.42(a).

1. Physical & Mental Restoration Services

* Physical and mental restoration services are services necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressing.

* Physical & Mental Restoration Services include:

Medical, surgical, or corrective treatment;

Diagnosis & treatment for mental or emotional disorders;

Podiatry;

Occupational, Physical, Speech, or hearing therapy;

Psychological services;

Dentistry;

Nursing services;

Necessary hospitalization in connection with surgery or treatment, and clinic services;

Convalescent or nursing home care;

Drugs and supplies;

Prosthetic, orthotic or other assistive devices including hearing aids essential to obtaining or retaining employment;
Eyeglasses and visual services, including examination, prescription, and provision of glasses, lenses, and other special visual aids;

Therapeutic recreation services;

Medical or medically related social services;

Treatment or either acute or chronic medical complications and emergencies related to the provision of these services, or which are inherent in the condition being treated;

Kidney treatment, including dialysis, transplants, and supplies;

Art, dance and music therapy, psychodrama, and other medical or medically related rehabilitation services.

29 U.S.C. Section 723(a)(4); 34 C.F.R. Sections 361.1; 361.42(a)(3)

2. Rehabilitation Engineering

* Rehabilitation Engineering was added to the list of Title I VR services in 1986. It is given preferential treatment in the Act, first by being a specific subject of discussion in the State plan, by being a service that must be considered for all persons as part of the Title I VR services eligibility process, and by being exempt from the consideration of "similar benefits."

* Rehabilitation engineering is defined as:

> the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with handicaps in areas that include education, rehabilitation, employment, transportation, independent living, and recreation (34 C.F.R. Section 361.1).

B. Individualized Written Rehabilitation Plan

* The Individualized Written Rehabilitation Plan ("IWRP") is the basic document outlining the vocational objective the individual will be working toward, and all the Title I VR services that will be provided. If the person is to be given an extended evaluation, the services to be provided during this period are to be listed (29 U.S.C. Section 722; 34 C.F.R. Section 361.40 - 361.41). (The IWRP is the equivalent for VR services to the IEP and IFSP for special education and early intervention.)

* The IWRP is to be developed jointly by the individual and the VR counselor, and the person's VR services must be provided consistent with its terms. The IWRP is to be reviewed as often as necessary, but not less than once per year (29 U.S.C. Section 722(b)(2); Section 361.40(b); (c)).

* The IWRP must contain the agreed upon vocational objective the person will be moving toward. The objective may be chosen from among any of the types of activities that fall within the term "employability" defined in 34 C.F.R. Section 361.1. The objective is to be developed through consultation between the individual with handicaps and the VR counselor. It may identify a particular job, or a more general vocational objective. The IWRP must then break apart the vocational objective into intermediate and long range goals (34 C.F.R. Section 361.41(a)).

* The IWRP must list all the services to be provided under the plan, and state the expected date by which each service is to be initiated. If rehabilitation engineering services are to be provided, they too must be stated on the IWRP. 34 C.F.R. Section 361.41(a)(3); (a)(5).

* The IWRP also must state whether, and if so, to what degree, the costs of services will be borne by the person, or by "similar benefits" (34 C.F.R. Section 361.41(a)(9)).

V. What Makes Vocational Rehabilitation An Assistive Technology Resource?

A. Introduction

* The Title I VR program is a very important source of assistive technology funding. It clearly states that funding for assistive technology is available, and makes consideration of the benefits of assistive technology a routine part of the process by which eligibility and services needs are determined.

* For children now in school, the Title I VR program should be considered as part of a continuum of services extending from the programs funded by the Education for All Handicapped Children Act. The EHA also is a source of assistive technology funding, but its mandate expires when the student graduates from high school or reaches age 21.

For many students, the last years of education can and should consist of a combination of education and vocational training programs, for which both the EHA and the Title I VR program can be a part. In particular, the two programs can address the student's needs for assistive technology, and determine which of the two will provide the necessary funding.

B. General Program Criteria Supporting Funding

* The Title I VR program includes 8 services that should be viewed as supporting assistive technology funding:

rehabilitation engineering;

telecommunications, sensory and other technological aids and devices;

prosthetic, orthotic or other assistive devices including hearing aids, essential to obtaining or retaining employment;

eyeglasses and visual services, including visual training,

physical therapy;

occupational therapy;

speech or hearing therapy;

special services for the treatment of individual[s] suffering from end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies;

on-going personnel development.

Each of these services is described below.

C. General Program Criteria Perceived As Funding Barriers

* The Title I VR program contains no express barriers to funding assistive technology devices and services.

* Nonetheless, the Title I VR program has many potentially significant barriers to its being used to its full potential as an assistive technology resource. State Tech Act staff will face a significant challenge, similar to the one presented by the EHA, to ensure that the Title I VR program operates as Congress intended. Five of these potential barriers include:

A Lack of Basic Knowledge

A Lack of Discretion by the VR Counselor

Title I VR Services Funding Levels

Order of Selection

Similar Benefits

Each of these potential barriers is described below.

1. Rehabilitation Engineering

* Congress added rehabilitation engineering to the Rehabilitation Act in its 1986 amendments. It did so after hearing testimony about the significant benefits technology can provide to persons with handicaps. The congressional report explaining the 1986 amendments discussed the importance of assistive technology at a number of places. These comments are valuable tools to show that Congress intended rehabilitation engineering to play a central role in the provision of Title I VR services.

* Three of these comments include:

> . . . In this highly technological age, there are almost infinite opportunities to reduce the limitations of individuals with disabilities; permitting a level of productivity that could not even be conceived of ten years ago.
>
> Rehabilitation engineering services can dramatically improve the employment potential of people with disabilities. The Committee believes that rehabilitation engineering services should be appropriately incorporated into the full spectrum of rehabilitation services. A substantial commitment on the part of the vocational rehabilitation system is required to train rehabilitation personnel, provide expert advice and promote research in the benefits and application of rehabilitation engineering.
>
> Language is also added to encourage the use of rehabilitation engineering services. The Committee heard testimony about the success of melding engineering and rehabilitation service delivery. Rehabilitation Engineering services have been defined as the application of engineering to "improve the quality of life of the physically handicapped through a total approach to rehabilitation combining medicine, engineering, and related services." It also refers to the 'provision of physical devices or the adaptation of the physical environment to enable physically handicapped persons to perform everyday activities in a workplace, in an educational setting, or in a home or other place of residence.
>
> The Committee is aware that modern technology has revolutionized the challenges faced by the rehabilitation system. The success of these efforts has been to potentially increase the number of disabled people who can participate in the labor force. Technology has itself been a major force in changing the disabled population. Advances in science and medicine have increased the life span and survival rate of people with many different types and severity of disabilities.
>
> Thus, the Committee believes that technology has the potential for improving the quality of life for people with disabilities, including improving communication, mobility, independence, and control of one's environment. Technology can provide important job opportunities for physically disabled persons through the adaptation of worksites. As we approach the 21st century, further advances in microcomputers, electronics and materials development can only further expand the frontiers of what we even consider as being possible today.
>
> House Rep. No. 99-571, pp. 20,22,27, reprinted in [1986] U.S. Code Cong. & Admin. News, p. 3471, 3490, 3492, 3497.

* These congressional observations resulted in rehabilitation engineering being given a special status in the Title I VR program. At the state level, the state plan must discuss how the state will increase the use of rehabilitation engineering services in the future. At the individual level, rehabilitation engineering must be considered in all eligibility determinations, and then must be provided without regard to whether any similar benefits may exist to address its costs.

* For an individual, rehabilitation engineering services can take many forms, including adaptive equipment to aid communication and mobility, modifications to vehicles, (e.g., wheelchair van controls, lifts, floor and ceiling modifications), home modifications, and/or worksite modifications.

- In general, rehabilitation engineering services can be viewed as a limitless opportunity for assistive technology devices to be provided to persons with handicaps through the Title I VR program. The key simply is to tie the rehabilitation engineering service to the person's vocational objective, i.e., one of the activities that comprise the definition of "employability."

2. Telecommunications, Sensory & Other Technological Aids & Devices

- This service will overlap some with the scope of rehabilitation engineering. It appears to cover any assistive technology device or service that will aid the ability of an individual with a disability to communicate, or to be aware of and be able to control his or her environment.

3. Prosthetic, Orthotic Or Other Assistive Devices Including Hearing Aids

- This service also will overlap some with the scope of both rehabilitation engineering and the telecommunications aids and devices. It appears to cover orthopedic prostheses, as well as communication devices and hearing aids.

- The key phrase included in this service: "essential to obtaining or retaining employment," actually is an inherent part of all the services within Title I. Employment, however, is tied not strictly to independent competitive employment, but to any of the activities listed in the definition of "employability."

4. Eyeglasses And Visual Services

- This service, like the preceding services, will overlap some with the scope of rehabilitation engineering. It appears to cover any assistive technology devices or services that will aid the individual see or read.

- The service specifically covers the full range of corrective lenses that may aid a person to see and read, as well as equipment that will aid in reading, such as a "personal reader," and scanners with speech synthesizers.

5. Physical, Occupational, Speech & Hearing Therapy

- These services are obvious sources of assistive technology. Professionals from these disciplines will be required to provide evaluations and recommendations for most of the assistive technology to be provided through rehabilitation engineering, and all the other services listed here. In addition, direct services beyond evaluation and recommendation are available through Title I.

6. Kidney Services

- Title I specifically lists special services for the treatment of individual[s] suffering from end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies.

* That Title I will cover these services is extremely valuable. The individual's insurance or Medicaid may not include the full range of these services. For example, states have the option of covering organ transplants, although the state may not then choose some organs but not others.

* The key to eligibility for this service is that because it is provided the individual will be able to secure or retain employment. There must be some connection between the provision of these services to the increase in the person's employability.

7. Ongoing Personnel Development

* State plans must include a provision for staff development. This provision is extremely important, particularly for rehabilitation engineering and assistive technology in general. In the 1986 amendments to the Rehabilitation Act, Congress noted that technology is changing at such a rapid rate that rehabilitation staff must undertake affirmative efforts to stay current with new developments.

* Although this provision provides no substantive right to individuals seeking Title I services, it is extremely important for State Tech Act staff. They should seek to ensure that this provision is faithfully followed.

8. A Lack Of Basic Knowledge Barrier

* Vocational Rehabilitation programs are decades old. Historically, VR programs served persons with a narrow range of impairments, and only a few employment related goals. Only recently has there been attention paid to the full range of handicapping conditions, or a broad definition given to "employability." This historically narrow focus to VR programs can create a significant barrier among local VR agency staff, and state VR program administrators to the adoption of assistive technology, or to finding persons with challenging handicaps to be "employable."

* This lack of basic knowledge of rapidly changing rehabilitation methods and technologies is further complicated by the varied "expertise" of the VR agency staff. Like the EHA, the standard for eligibility for services is extremely subjective.

* Overcoming the limited knowledge of VR agency staff has two dimensions. First, State Tech Act staff must ensure that ongoing staff development occurs, as is mandated by each state plan. Tech Act staff also must ensure that the state plan requirement for discussion of ways to increase the use of rehabilitation engineering services is more than an 'on-paper' discussion. These plans must be put into effect in every VR agency office in each state.

* Tech Act staff can look for reinforcement on these issues to the recently published policy memorandum from Commissioner Nell C. Carney.

* Second, at the individual level, applicants for VR services must be made aware of their right to have a rehabilitation engineering assessment, and of the congressional support for assistive technology in VR programs. They must be informed and directed to insist on having rehabilitation engineering, and any other service that supports assistive technology, included on their IWRP.

* Applicants also must be educated not to accept a rejection for services without filing an appeal that will be heard by an independent hearing officer. The scope of "employability" is simply too great to suggest that many people will be held to have no rehabilitation potential.

* In addition, the Client Assistance Program, and Independent Living Centers, which provide counseling and representation for Title I VR services applicants, must be educated concerning rehabilitation engineering and assistive technology. They too must be encouraged to use every advocacy resource to ensure that neither complete, nor specific services rejections are left unchallenged.

9. Lack Of Discretion By The VR Counselor

* Individual VR counselors, who work with individuals with handicaps to develop IWRPs, in fact, may have very little authority to commit the agency to providing any specific services. That authority often is reserved for more senior managers.

* One reason to restrict the discretion of individual staff is that it is a means to exercise control over limited financial resources. The argument favoring such control is that allowing many persons to commit the VR program to provide specific services, without regard to the activities of each other, precludes an awareness of the impact their decisions have on the overall (limited) program budget.

* By limiting discretion of the staff, and concentrating approval authority in managers who are removed from the individuals with handicaps, services are denied, and vocational objectives are arbitrarily limited. Although the IWRP process is expected to look solely at what is the most beneficial equipment, programs and services for particular individuals, the VR agency may apply very different criteria. VR counselors may create rationales of denial or inappropriateness because managers do not authorize non-ordinary, and/or expensive IWRP contents.

* The solution to this problem is the same as the lack of basic knowledge barrier. State Tech Act staff, as well as CAP and Independent Living Center staff must insist on the development of IWRPs consistent with the extraordinarily broad language contained in the Rehabilitation Act and rules. Becoming aware of the limits on the discretion of individual counselors is the first step. Then reforming the decision making process, as well as insisting on the application of the proper eligibility criteria in individual

U.S. DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION
AND REHABILITATION SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D.C. 20202

POLICY DIRECTIVE
RSA-PD-91-03
RSM-2040 1/
DATE: November 16, 1990

TO: STATE VOCATIONAL REHABILITATION AGENCIES (GENERAL)
STATE VOCATIONAL REHABILITATION AGENCIES (BLIND)
RSA DISCRETIONARY GRANTEES
CLIENT ASSISTANCE PROGRAMS
RSA SENIOR MANAGEMENT TEAM

SUBJECT: Policy Statement on Rehabilitation Engineering
(See also RSA-TAC)

BACKGROUND: The 1986 Amendments to the Rehabilitation Act of 1973 (Public Law 99-506) placed a new emphasis on the provision of rehabilitation engineering services. The term "rehabilitation engineering" as defined in the Act means: "... the systematic application of technologies, engineering methodologies or scientific principles to meet the needs of and address the barriers confronted by individuals with handicaps in areas which include education, rehabilitation, employment, transportation, independent living, and recreation." With the enactment of Public Law 99-506, the rehabilitation process reached a new milestone in the continuum of services for individuals with disabilities by expanding their opportunities for a better quality of life.

POLICY STATEMENT: It is the policy of the Rehabilitation Services Administration (RSA) to promote, encourage and support the application of rehabilitation engineering technology in the provision of services to people with disabilities. Rehabilitation technology encompasses a range of services and devices which can supplement and enhance individual functions. It also encompasses services which impact the environment through environmental changes, such as job re-design or worksite modifications. Rehabilitation technologists may employ one or both types of

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1/ Under development.

services in order to enhance employment opportunities for an individual. Any evaluation of a client's need for rehabilitation technology services must be performed by personnel skilled in rehabilitation engineering technology.

Application of rehabilitation engineering services is especially important when making determinations of eligibility. This is particularly so for those individuals whose disabling conditions are of a severity that otherwise might lead to a finding of ineligibility. Application of these technologies, methodologies and principles are equally important for those individuals who are:

- In extended evaluation to determine rehabilitation potential
- Receiving services under an individualized written rehabilitation program (IWRP) if such services are appropriate
- Undergoing annual review when the case was closed as too severe
- Undergoing annual review and re-evaluation when the case is in extended employment in rehabilitation facilities
- Receiving post-employment services.

The Federal statute stipulates that the provision of rehabilitation engineering services by State vocational rehabilitation (VR) agencies is not conditioned on a determination that comparable services and benefits are unavailable under any other program. This does not mean, however, that if such services are readily available to the individual from other sources they should not be utilized by VR agencies.

RSA is strongly committed to the utilization of the expertise available through rehabilitation engineering. Each State VR agency must provide, as an attachment to its Three Year State Plan under Title I a description of how rehabilitation engineering services will be provided to assist an increasing number of individuals with handicaps.

CITATIONS IN LAW:

Section 7(5)(H), and (12), Section 101(a)(5)(c), Section 101(a)(8), 101(a)(9), 101(a)(16), Section 102(a) and (b) and (c), Section 103(a)(1)(A), Section 103(a)(12), of the Rehabilitation Act of 1973, as amended

CITATIONS IN REGULATIONS:
34 CFR 361.1
34 CFR 361.2(b)(1)(i)
34 CFR 361.32(c)
34 CFR 361.33(b)
34 CFR 361.34(b) and (e)(2)
34 CFR 361.35(d)
34 CFR 361.40(c) and (d)
34 CFR 361.41(a)(3)
34 CFR 361.42(a)(15) and (b)
34 CFR 361.47(b)(2)(v)
34 CFR 361.58

EFFECTIVE DATE: Upon issuance

POLICY DELETED: None

INQUIRIES TO: Regional Commissioners

Nell C. Carney

Nell C. Carney
Commissioner of Rehabilitation
Services Administration

cc: CSAVR
NAPAS

U.S. DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION
AND REHABILITATIVE SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D.C. 20202

TECHNICAL ASSISTANCE CIRCULAR
RSA-TAC- 91-01
RSM-2040 1/
DATE: November 16, 1990

TO: STATE VOCATIONAL REHABILITATION AGENCIES (GENERAL)
STATE VOCATIONAL REHABILITATION AGENCIES (BLIND)
CLIENT ASSISTANCE PROGRAMS
RSA DISCRETIONARY GRANTEES
RSA SENIOR MANAGEMENT TEAM

SUBJECT: Rehabilitation Engineering Technology (See also RSA-PD - 91-03)

BACKGROUND: The 1986 Amendments to the Rehabilitation Act of 1973 (Public Law 99-506) placed a new emphasis on the provision of rehabilitation technology services. The term "rehabilitation engineering" is defined in the Act at Section 7(12) as: "the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with handicaps in areas which include education, rehabilitation, employment, transportation, independent living, and recreation." With the addition of this definition of rehabilitation engineering, and other provisions regarding an assessment of the need for rehabilitation engineering services throughout the rehabilitation process incorporated into the Act by Public Law 99-506, it is clear that Congress intended that greater emphasis be placed on the furnishing of rehabilitation technology.

In an effort to provide information to the States for training purposes regarding the Act and the intent of Congress about the increased provision of rehabilitation technology, the National Institute on Disability and Rehabilitation Research (NIDRR) funded a grant in October 1986 to the University of Wisconsin-Stout for the Thirteenth Institute on Rehabilitation Issues (IRI) to develop a publication entitled Rehabilitation Technologies. This publication is an excellent source of information and can be purchased through the National Clearing House, Oklahoma State University, 816 West 6th Street,

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1/ Under development.

Stillwater, Oklahoma 74078, or the Research and Training Center, School of Education and Human Services, University of Wisconsin-Stout, Menomonie, Wisconsin 54751.

Subsequent to enactment of the 1986 amendments to the Rehabilitation Act of 1973, Congress passed and the President signed Public Law 100-407, Technology Related Assistance for Individuals with Disabilities Act, known as the "Tech. Act". As of this date, twenty-three (23) grants have been awarded to States for the development and implementation of consumer-responsive programs of technology-related assistance for individuals of all ages with disabilities. Of the 23 State grants presently funded, 13 were awarded to State vocational rehabilitation (VR) agencies as the lead agency. In addition, NIDRR has funded a national technical assistance contract to assist States in implementing plans in the area of technology. This technical assistance contract was awarded to RESNA (formerly the Rehabilitation Engineering Society of North America). For further information contact Ms. Karen Franklin, Program Director, RESNA, Suite 700, 1101 Connecticut Avenue, NW, Washington, D.C. 20036. Ms. Franklin's telephone number is (202) 857-1140.

The dramatic growth of technology has added many new devices, aids, and enhancements which can effectively eliminate many barriers encountered by individuals with disabilities. Rehabilitation technology is available either to substitute for functions lost through disability, or to supplement or enhance existing functions in order to expand employment and independent living opportunities. Thus, it encompasses a range of services which can supplement and enhance individual functions. It also encompasses services which impact the environment through environmental changes, such as job re-design or worksite modifications. Rehabilitation technologists may employ one or both types of services in order to enhance employment opportunities for an individual. Today, the use of rehabilitation technology significantly increases the ability of rehabilitation agency clients in achieving independent and productive lives. Rehabilitation technology greatly enhances the effectiveness of other rehabilitation agency services and activities.

GUIDELINES AND SUGGESTED METHODS:

A. Evaluation of VR Potential

Section 103(a)(1)(A) of the Act requires that each State VR agency when conducting an evaluation of VR potential (or extended evaluation to determine VR potential) must provide if appropriate, rehabilitation engineering services to any individual with a handicap in order to assess and develop the individual's capacities to perform adequately in a work environment. An evaluation of a client's need for rehabilitation engineering services must be performed by personnel skilled in rehabilitation engineering technology. Rehabilitation engineering services can be provided by VR State agencies without consideration of the availability of comparable services and benefits from any other program. However, where rehabilitation engineering services are readily available to the individual from other sources such resources should be used.

B. The IWRP

If rehabilitation engineering services are an integral component to the rehabilitation of an individual with handicaps, the individualized written rehabilitation program (IWRP) must identify the specific rehabilitation engineering services to be provided to assist in the attainment of intermediate objectives and long-range rehabilitation goals for the individual [Sec 102(b)(1)(D)]. Such services are exempt from the requirement to use comparable services and benefits available under any other program; however, where rehabilitation engineering services are readily available to the individual from other sources it is prudent to use such resources at any point in the rehabilitation process.

C. Economic Need

State VR agencies can not condition the provision of an evaluation of rehabilitation potential, including diagnostic and related services (which is part of the determination of eligibility), on economic need. Under a program of extended evaluation to determine VR potential, rehabilitation engineering services, other than of a diagnostic nature, may be subject to economic need if a State so elects.

There is no Federal requirement that the financial need of an individual with handicaps be considered in the provision of any VR services, including rehabilitation engineering services. If a State VR agency establishes an economic needs test for rehabilitation engineering services, or for any other service for which an economic needs test is permitted, the State VR agency must maintain written policies identifying the criteria and methods for determinating financial need. Such policies must be applied uniformly so that equitable treatment is accorded all individuals with handicaps in similar circumstances.

An economic needs test may be applied for the provision of rehabilitation engineering services as a post-employment service necessary for the individual to maintain or regain other suitable employment. The needs test policy, however, can be no more restrictive for a client who is receiving rehabilitation engineering as a post-employment service than that which was applied to such service prior to the client's having been determined rehabilitated.

D. Reviews

The IWRP must be reviewed as often as necessary but at least on an annual basis. Each individual with handicaps or, as appropriate, that individual's parent, guardian, or other representative, must be given the opportunity to review the IWRP and, if necessary, re-develop and agree to its terms [Sec. 102(b)(2)]. The utilization of rehabilitation engineering technology may lead to a re-development of the IWRP with revised intermediate and long-range rehabilitation objectives.

When conducting an annual review of any case closed after services were begun because the individual was found to be incapable of achieving a vocational goal and was therefore no longer eligible, such review should, as appropriate, utilize the expertise available through rehabilitation engineering and related technology. The State VR agency is responsible for initiating the first review of the ineligibility decision. Any subsequent reviews should also utilize the expertise available through rehabilitation engineering technology.

In meeting the requirement for periodic review and re-evaluation, at least annually, of those individuals closed in extended employment in rehabilitation facilities, maximum use of rehabilitation technology should be made in identifying and evaluating those individuals' capabilities for competitive employment.

E. State Plan

Each State VR agency must provide, as an attachment to its Title I Three Year State Plan, a description of how rehabilitation engineering services will be provided to assist an increasing number of individuals with handicaps.

This attachment can address the methods undertaken by the State VR agency to train professional staff in the utilization of rehabilitation technology in areas such as (1) evaluating client needs; (2) providing technical assistance to employers to foster job development, job modification, and architectural accessibility; (3) providing technical assistance to public schools if there is a program of transitioning clients from school to work; and (4) providing technical assistance to the business community in creating employment opportunities. This description should be tied into the findings of Statewide studies and the annual evaluation of the State VR agency's program as well as the methods used by the State VR agency to expand and improve services to those individuals who have the most severe handicaps as required by attachment 8.4A of the State plan.

F. Written Policy

As is the case with all other VR services for individuals, each State VR agency must establish and maintain a written policy on the nature and scope and the conditions, criteria, and procedures under which rehabilitation engineering services are to be provided. This written policy should address the need for rehabilitation engineering services at any time in the rehabilitation process, including evaluation of rehabilitation potential (preliminary and thorough diagnostic study), extended evaluation, services provided under an IWRP, annual reviews of ineligibility decisions, annual reviews of extended employment in rehabilitation facilities, and post employment services.

In establishing its policies, State VR agencies have the discretion under Section 101(a)(6)(A) of the Rehabilitation Act and 34 CFR 361.42(b) to establish a reasonable fee schedule and a maximum dollar limit on reimbursement for a particular service, provided the limit (1) is designed to ensure the lowest reasonable cost to the program for such a service, (2) is not so low as to effectively deny any client a necessary service, and (3) is not absolute and permits exceptions so that individual client needs can be addressed.

When applying these policies, State VR agencies' guidelines on "case services annual dollar limits" and "specific service dollar limits" must take into account the following principles based in law and regulations.

1. Service decisions should not be subject to arbitrary, categorical limitations on expenditures when the applicant is eligible and the service is otherwise appropriate.

2. Reasonable fee schedules should be established; however, fee schedules should be sufficiently flexible to allow for exceptions to established limits based upon appropriate justification of a client's individual needs and circumstances.

3. Regulations contained in EDGAR (34 CFR Part 80.22(b) - OMB Circular A-87) provide, in part, that costs to be allowable under a grant program must be necessary and reasonable for the proper and efficient administration of the grant program.

4. There is an obligation to exercise prudence in the development of a client's IWRP. Employment objectives must be realistic and attainable within the constraints of funds available to the VR program.

These principles govern all goods and services which are available to eligible clients under the State agency's plan of services for individuals with handicaps.

G. Additional Sources of Information

National Rehabilitation Information Center (NARIC)
8455 Colesville Road, Suite 935
Silver Spring, Maryland 20910-3319.

NARIC produces a bibliographic database, REHABDATA, covering disability related research literature. REHABDATA includes citations to research reports from NIDRR-sponsored centers and other sources, scholarly papers, and selected journal articles as well as audiovisual materials and reference documents.

ABLEDATA SERVICES
Newington Children's Hospital
181 East Cedar Street
Newington, Connecticut 06111

ABLEDATA maintains and updates a database of commercial products for use in all aspects of independent living.

Job Accommodation Network (JAN)
West Virginia University
809 Allen Hall
Morgantown, West Virginia 26506
Project Manager: Barbara Judy
(800) 526-7234

Financing Adaptive Technology: A Guide to Sources and Strategies for Blind and Visually Impaired Users by

Steven B. Mendelsohn
Smiling Interface
Post Office Box 2792
Church Street Station
New York, New York 10008-2792
(212) 222-0312

This book develops strategies for financing rehabilitation technology that is appropriate for the non-blind population as well.

National Clearing House of Rehabilitation Training Materials
816 West 6th Street
Oklahoma State University
Stillwater, Oklahoma 74078
(405) 624-7650

STATUTORY AND REGULATORY CITATIONS:

(1) Sections 7(5)(H), and (12), 101(a)(5)(C), 101(a)(8), 101(a)(9), 101(a)(16), 102(a) and (b) and (c), 103(a)(1)(A), and 103(a)(12) of the Rehabilitation Act of 1973, as amended

(2) 34 CFR Sections 361.1, 361.2(b)(1)(i) and (2)(iii), 361.32(c), 361.33(b), 361.34, 361.35(d), 361.39, 361.40, 361.41, 361.42(a)(15) and (b), 361.47(a) and (b)(2)(v), and 361.58

INQUIRIES: RSA Regional Commissioners

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Commissioner of Rehabilitation
Services Administration

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cases must follow.

10. Title I VR Services Funding Levels Barrier

* "It's too expensive" is a frequently cited reason to deny necessary and appropriate services of all kinds to persons with handicaps of all ages. As to Title I VR services, the reason is not a valid excuse. The Act specifically describes an enormous range of services that are expensive, either individually, or collectively, yet they required to be provided. If Congress, or the Rehabilitation Services Administration determined that these expensive services are required services, the state VR agency, or an individual VR counselor or manager has no authority to refuse to add it to an IWRP.

* Title I VR programs are funded at approximately the same level as the EHA. However, unlike the EHA, whose funds are spread among thousands of individual school districts, VR funding is concentrated among the state VR agencies. What is needed is not necessarily more money: funds could be saved simply by increasing the coordination between the VR agency and the state education department. This is particularly true in the area of assistive technology, an expensive service, and one that often involves durable equipment that will last many years.

* Increasing interagency coordination (i.e., to ensure the state receives the greatest federal reimbursement for every expenditure) is encouraged in the Rehabilitation Act (29 U.S.C. Section 721(a)(11)).

11. Order of Selection

* Congress has recognized that more persons may seek rehabilitation services than there are funds appropriated to assist them. The result is the mandate that states include an "order of selection" to go into effect whenever the state feels it will be incapable of meeting all the needs of its applicants for services.

* The order of selection is required to ensure that persons with the most severe handicaps are served first. This may appear counterintuitive: in times of scarce resources, the expectation would be that the states will seek to stretch the limited funds as far as possible, i.e., to serve the maximum number of individuals with disabilities. Application of these values leads scarce dollars to be devoted to the simple cases, which may yield success in a short time.

* However, the order of selection mandate incorporates a different set of values: Congress recognized that a goal of maximizing the numbers of people served would result in the denial of services perceived to be too expensive, or with too low a probability of success. Most likely persons with more severe impairments would be denied services. To prevent the exclusion of persons with severe impairments from access to Title I VR services, Congress mandated that the first priority for service under the order of selection must be persons with severe impairments, even though their services needs may be more expensive, and their IWRPs may defy a simple definition of success.

* The order of selection, per se, should not be a barrier to the provision of assistive technology. Often, persons needing assistive technology will be represent persons with the most severe impairments. They must be served first. In addition, the order of selection addresses people, not services. Anyone who can meet the criteria for the first priority should be given all the services s/he requires.

12. Similar Benefits

* The requirement that some VR services be provided only after consideration whether there are "similar benefits" available to meet their costs may be cited as an excuse, but is not a valid reason to deny a service. The IWRP should still state that the service is needed, and should still list the service as being provided. All that is required is for the service to be paid for by another agency.

* The value of including services on the IWRP that are paid for by agencies other than the Title I VR agency is that the IWRP becomes a true plan, not merely a statement of the VR agency's responsibilities. It states the responsibilities of the VR agency, the individual, and other agencies as well. Taken together, if these services are provided, the individual is expected to achieve the stated vocational objective.

* The provision of rehabilitation engineering is exempt from the similar benefits analysis. Thus, in regard to assistive technology, the all inclusiveness of rehabilitation engineering will not be compromised by claims that an agency other than the VR agency should/must pay for it.

Part B. Projects With Industry

I. Introduction

* Projects with Industry ("PWI") is a small grants program created in 1968. Its purpose is to provide training and to create job opportunities in the competitive economy for persons with handicaps. Congress stated that the purposes of this program are to

> promote opportunities for competitive employment of individuals with handicaps, to provide appropriate placement resources, to engage the talent and leadership of private industry as partners in the rehabilitation process, to create practical settings for job readiness and training programs, and to secure the participation of private industry in identifying and providing job opportunities and the necessary skills and training to qualify individuals with handicaps for competitive employment (29 U.S.C. Section 795g(a)).

For FY 1991, approximately $20 million is available for distribution (Section 795i).

* In 1986, PWI served 14,000 persons, most of whom have severe handicaps. Of this total, 12,000 were placed in competitive employment jobs. In addition to severe

handicaps, participants generally had no education beyond high school, and had a long period of unemployment prior to entering the program. Despite their impairments and unemployment, these persons were not viewed as "unable to work" or "disabled" by other benefits programs. Approximately 25 percent had mental illness; 20 percent had orthopedic impairments; and 15 percent had mental retardation.

* Projects with Industry is a grants program. It is unlike any of the other federal funding programs discussed in this manual. It is the only one that does not require a state plan, and it is not administered by a state agency. Instead, it operates through cash grants distributed directly by the U.S. Department of Education. Organizations submit proposals in response to priorities established by the Rehabilitation Services Administration. Through a peer review process successful applicants are selected.

A. Overlap With Title I VR Services Program

* PWI complements the Title I VR services program in many respects. First, it is a means by which employers, or others interested in expanding the competitive work opportunities for persons with handicaps, to give effect to their ideas and goals. The employer or training organization is the principal actor in the PWI program, as compared to the individual who is the focus of the Title I VR services program.

* In addition, the PWI program is designed to aid groups of individuals with handicaps. Grants are unlikely to be approved to permit an employer to hire or accommodate a single individual with handicaps. For a single individual, the Title I VR services program should provide the devices or services required to gain or retain their employment.

II. Individual Eligibility Criteria

* Projects with Industry are one of 8 "Vocational Rehabilitation Services Projects" identified in the Rehabilitation Act regulations in 34 C.F.R. Section 369.2. These rules complement 34 C.F.R. Part 379, which describe the specific goals and eligibility criteria for this grants program.

A. Who Is Eligible For A Projects With Industry Grant?

* Any of the following organizations or entities are eligible to apply for a Projects with Industry grant:

(a) designated state unit (the Title I VR services agency);
(b) industrial, business, or commercial enterprise;
(c) labor organization;
(d) employer;
(e) industrial or community trade association;
(f) rehabilitation facility; or
(g) other agency or organization with the capacity to arrange, coordinate,

or conduct training and other employment programs and provide supportive services and assistance for individuals with handicaps in a realistic work setting.

These organizations may be not for profit, as well as profit making enterprises (34 C.F.R. Section 369.2(g); Section 379.2).

B. Required Contents of Grant Applications & Review Criteria

* Applications for funding are judged according to criteria set forth in Part 379. Additional criteria have been stated for projects that require funding for more than one year.

* The rules state ten decision making criteria to judge initial applications for funding:

(a) Overall plan of operation.

The application must contain a plan of operation, including the project design; a management plan; a description of how the objectives of the plan relate its purposes; an explanation of how the applicant will use its resources and personnel to achieve each objective; and a description of how the applicant will provide equal access to all program participants (34 C.F.R. Section 379.30(a); 369.31(a)).

(b) Quality of key personnel.

The application must identify the project director and any other key personnel who are to be involved with the project. The experience, qualifications, and time commitment to the project for all key personnel will be judged (34 C.F.R. Section 379.30(b); 369.31(b)).

(c) Budget & cost effectiveness.

The budget for the project must be sufficient to achieve its stated objectives, and the costs must be reasonable in light of those objectives (34 C.F.R. Section 379.30(c); Section 369.31(c)).

(d) Evaluation plan.

Each application must contain an internal review that will ensure the project is on track, and continuing to move toward the project objectives. To the extent possible, objective criteria should be included. For multiple year projects, the objective criteria are stated in the regulations (Section 379.53 34 C.F.R. Section 379.30(d); 369.31(d)).

(e) Adequacy of Resources.

Projects must describe the commitment of existing organizational resources to the project, including facilities, equipment and supplies. This requirement complements the personnel commitment which is separately evaluated (34 C.F.R. Section 379.30(e); 369.31(e)).

(f) Achievement of competitive employment objectives.

The competitive employment objectives for the individuals being served under the grant, as well as how those objectives will be achieved must be described.

These objectives should include placing a substantial number of individuals with handicaps in competitive employment on a cost-effective basis; ensuring that individuals

will be trained in occupations for which there is a realistic demand in the competitive labor market; that the jobs created will offer career development and advancement opportunities; and that when the participating individuals complete their training, they will be employed (34 C.F.R. Section 379.43(g).
34 C.F.R. Section 379.30(f)).

(g) Coordination with service agencies.

Proposed projects must describe how they will coordinate with the state Title I VR services agency, and other community services agencies. Included among the coordination tasks is the selection of the individuals to be served, which is to be done with the state Title I VR services agency (34 C.F.R. Section 379.43(f)) 34 C.F.R. Section 379.30(g)).

(h) Innovativeness of approach.

The final criterion is a review of the creativity and innovativeness of the goals, methods, and objectives of the proposal. Does the project intend to bring individuals with handicaps into an industry in which they never have been included; does the project intend to employ them in ways never contemplated before; does it intend to employ individuals with particular handicaps who have previously been excluded from the industry, etc.? (34 C.F.R. Section 379.31(h)).

* Additional requirements are stated in the form of "assurances" that all proposed projects must provide as a condition of funding. Among them is that persons employed as part of a PWI grant will receive all the benefits of other employees, and that no segregation of individuals with handicaps will occur within the workplace (34 C.F.R. Section 379.43(j); (k)).

* Another assurance is that persons employed under a PWI grant are paid the same wages as any other trainees in the particular enterprise (34 C.F.R. Section 379.44(a)).

* Projects with Industry can be funded for a period of five years (34 C.F.R. Section 379.43(h)).

* For projects that will continue for more than one year, the regulations state a set of objective criteria that will be used to determine whether ongoing funding will be provided.

The application of these criteria will determine whether an acceptable minimum amount of progress is being made to permit continued funding. These criteria include a review of the following:

A minimum of 50% of the persons served by the project must have severe handicaps.

The application must state an expectation of the number of program participants who will be placed. For continued funding, at least 50% of the projected number of participants must be placed.

A minimum of 50% of the persons being served must have been unemployed for at least 6 months prior to entry into the project.

Although the regulations stress serving persons with severe handicaps, and those who previously had been unemployed for a long time, the rules state that the average cost per placement cannot be greater than $1600.

As part of the application, a projected cost per placement must be stated. Upon review, costs cannot be greater than 140% of the projection.

At least 40% of program participants must be placed in competitive employment as a result of program participation.

Following program participation, i.e, placement in the competitive economy, the grant recipient must show that participants have increased their earnings by at least $75.00 per week above their pre-participation income.

Just as at least 50% of program participants must have severe disabilities, at least 50% of the persons placed must have severe disabilities.

Just as 50% of program participants must have long periods of prior unemployment, at least 50% of the persons competitively employed must have at least 6 months of pre-participation unemployment (34 C.F.R. Section 379.53).

III. Covered Programs & Services

* There are four principal types of activities that will be assisted through PWI grants. These include:

(a) training and employment in a realistic work setting;

(b) supportive services that are necessary to permit individuals with handicaps to continue to engage in the employment or a related type of employment for which they have received training under a PWI grant;

(c) expanding job opportunities for individuals with handicaps by analyzing job demands and capabilities of the individuals with handicaps and providing for:

(1) the development and modification of jobs to accommodate the special needs of the individuals being trained and employed under a PWI grant;

(2) the purchase and distribution of special aids, appliances, or equipment adapted to the needs of an individual with handicaps for use at a jobsite;

(3) the modification of any facilities or equipment of the employer which are to be used by individuals with handicaps under a PWI grant;

(4) the establishment of appropriate job placement services;

(d) Providing for business advisory councils that will identify available jobs within the community and the skills necessary to fill those jobs, and prescribe appropriate training programs (34 C.F.R. Section 379.10).

* In addition, the regulations state seven types of costs that will be covered as part of the PWI grant:

job training, vocational rehabilitation services, and supportive rehabilitation services;

instruction and supervision of trainees;

training materials and supplies;

instructional aids;

insurance;

purchase or modification of equipment or facilities adapted for use of individuals with handicaps and special aids and appliances;

alteration and renovation appropriate and necessary to ensure access to and utilization of buildings by persons with handicaps (34 C.F.R. Section 379.41).

IV. What Makes Projects With Industry An Assistive Technology Resource?

* Projects with Industry are a potential resource for assistive technology for individuals with handicaps. Although it is a small grants program, its regulatory provisions make clear that it can be used to increase the employability and employment of individuals with handicaps who will require assistive technology devices and services.

A. General Program Criteria Supporting Funding

* The PWI regulations state expressly that assistive technology is a covered cost if needed to serve project participants. However, the regulations do not state any specific devices or services that can be funded. Instead, they describe activities for which funding is available, and which can include assistive technology devices and services.

* The funding of specific assistive technology devices and services need not be part of the PWI grant. As noted above, program participants must be determined to be appropriate by the Title I VR services agency (34 C.F.R. Section 379.43(f)). For this reason, the PWI grant would not need to include the costs of any service that could be funded through the Title I VR services program. As noted in Part A, the availability of assistive technology under the Title I VR services program is almost limitless.

* A review of the PWI program is required to determine where PWI does not overlap with the Title I VR services program, and whether any of the unique programs and services support assistive technology funding. For example, two services listed under the PWI program clearly overlap with the Title I VR services program:

1. supportive services needed for individuals with handicaps to secure or retain employment, and

2. purchase of special aids, appliances or equipment adapted to the needs of an individual with handicaps.

* There is one unique PWI program criteria that can be seen as supporting funding for assistive technology: modification, alteration or renovation of facilities or equipment for use by individuals with handicaps.

This factor is described below.

B. General Program Criteria Perceived as Funding Barriers

* There are no express assistive technology funding barriers stated in the PWI regulations. However, one factor can be seen as a potential barrier:

> coordination with the Title I VR services agency for the purposes of participant selection.

This factor is described below.

1. modification, alteration or renovation of facilities or equipment for use by individuals with handicaps.

* A PWI grant can propose modifications to equipment and facilities that go beyond the scope of the Title I VR services program. Installation of elevators, accessible corridors, bathrooms, etc., may be required for an employer to add individuals with handicaps to its workforce. This may be an appropriate use of PWI funds. Similarly, the purchase of new equipment, with modifications enabling its use by individuals with handicaps, also is a possible PWI subject.

* For example, a manufacturing company may be considering the purchase of new equipment, such as an industrial drill press or lathe. If this equipment is available in a configuration that will allow the employer to employ individuals with handicaps, then an appropriate PWI project may be to train the individuals in the specific work tasks, and to purchase the adapted equipment. In addition, if the employer needs to re-design plant corridors, bathrooms, and the delivery system for raw materials to the adapted worksites, these facilities and equipment modifications also would be appropriate for a PWI grant. Because the equipment and other worksite adaptations are not individual specific, they would not be covered under the Title I VR services program.

2. Coordination with the Title I VR Services Program for the purposes of participant selection

* The coordination with the Title I VR services program is a mixed requirement. It benefits the potential impact of PWI grants by allowing extremely scarce funds to be used for unique programs and services, for which there is no duplication in the

Title I program.

- On the other hand, as noted in Part A, the Title I program does not have a long or distinguished history in terms of serving individuals with severe disabilities. Typically, these individuals were rejected for VR services because they were seen as lacking rehabilitation potential. The history of the "supported work program" includes many individuals who were rejected for Title I VR services, yet were able to enter competitive employment with appropriate supports.

- The same conflict in vision may also impact negatively on the PWI program. The identification of rehabilitation potential is extremely subjective, and the difference between a positive or negative finding of employability may be "inches." For persons with severe handicaps, the decision is all the more difficult. Yet this is the precise group of individuals that the PWI grants are designed to assist. An employer, or training program may find it difficult to win the support of the Title I VR services program in regard to the competitive employment potential of individuals with severe handicaps.

- To counter the potential for the Title I VR services program to negatively influence a possible PWI grant applicant, the state Tech Act staff must undertake two activities. First, it must seek to educate potential employers of the PWI program's existence, and to encourage as many as possible within given industries to submit joint grant proposals. Also, because grants must demonstrate a low cost per placement (current experience is about $1600 per placement), Tech Act staff must be able to refer potential PWI applicants to expert rehabilitation engineers to develop least-cost means to modify equipment and worksites.

- At the same time, Tech Act staff must work vigorously to educate Title I VR services staff to the potential employability of individuals with severe disabilities.

Part C. Supported Employment

I. Introduction

- Supported Employment for individuals with severe handicaps is a small formula grants program available to the states ($27.6 million appropriated for FY 89), created by the 1986 amendments to the Rehabilitation Act (29 U.S.C. Section 706(18); 795j - 795q; 34 C.F.R. Part 363). It also is known as "supported work," "Title VI," or "Part C."
- Supported work is extremely important because it is one of very few programs that are designed to break the patterns of un- and under-employment experienced by persons with handicaps, particularly those with severe handicaps. Before supported work was conceived, these persons were completely unproductive. Their days were spent either at home, in intermediate care facilities, or in day treatment centers. Or, they were spending their days in sheltered workshops, not utilizing all their abilities, and not receiving wages that reflected their abilities.

- Like the Title I VR services program, supported employment is a joint federal-state funded program, based on a state providing assurances of compliance with specific federal requirements.

- Prior to enactment of the 1986 Rehabilitation Act Amendments, a few supported work demonstration projects were funded by the Department of Education, Office of Special Education & Rehabilitation Programs, through demonstration project grants. OSERS described supported work at congressional hearings held in regard to the 1986 Amendments. Supported work was described as having four characteristics:

(1) Service Recipients: Supported employment is designed for individuals who are served in day activity programs because they appear to lack the potential for unassisted competitive employment.

(2) Ongoing Support: Supported employment involves the continuing provision of training, supervision, and support services that would be available in a traditional day activity program. Supported employment is not designed to lead to unassisted competitive work.

(3) Employment focus: Supported employment is designed to produce the same benefits for participants that other people receive from work and these can be assessed by normal measures of employment quality, e.g., income level, quality of working life, security, mobility and advancement opportunity.

(4) Flexibility in support strategies: Supported employment incorporates a variety of techniques and services to assist individuals obtain and perform work. Examples include: assistance to a service agency that provides training and supervision at an individual'sworksite; support to an employer to offset the excess costs of equipment or training; supervision of individuals with severe disabilities; and salary supplements to a coworker who provides regular assistance in performance of personal care activities while at work.

- Supported work provisions were then added to the 1986 Amendments, and thereby became a separate "outcome," like competitive employment, toward which vocational rehabilitation services could be provided to an individual with handicaps. Supported work complements the Title I VR services program by offering services to persons who historically were seen as too severely impaired to be competitively employed.

- Specifically, supported work is designed to assist persons who will require on-going post employment services, which typically have not been available. Supported work, as its name implies, provides the job training and initial on-the-job assistance these persons require.

* However, the extraordinary promise of supported work may not be realized because scope of its funding is limited. Congress provided funding for initial on-the-job assistance, but stated that funding for "extended" or on-going support services could not be paid from Rehabilitation Act funds. Instead, Congress extended to supported work the concept of time limited post-employment services found in the Title I VR services program. Congress has challenged the states to find additional funds for supported work extended services either through other federal funding, or non-federal sources (See H.Rep.No. 99-571, 99th Cong. 2d Sess. 31-32, reprinted in [1986] U.S. Code Cong. & Admin. News, 3471, 3501-02).

* By imposing this limit, Congress made success in the supported work program dependent on other sources of funding. Through this provision, supported work is unique among the programs described in this manual. Medicaid, special education, and even the Title I VR services program are all "complete" within their own statutory and regulatory provisions. Although the laws and rules may promote cooperative agreements with other programs, or create overlaps of funding responsibilities, such as between Medicaid, special education and early intervention, the programs still are able to function independently.

* Supported work, by contrast, cannot. To be successful, participants in supported work must be able to transition from VR program funding to programs funded by other sources. Their opportunity to continue in their supported work positions will be dependent on "extended services," which must be funded by sources other than the state supported work program. State Tech Act staff have an important role to ensure their states meet the extended services needs of supported work participants.

* Although it is both a relatively new, and small program, supported work is a success. Thousands of persons with severe handicaps are now employed in meaningful work and are receiving real wages for the first time. They have become taxpayers, instead of just services and benefits recipients. Equally important, the employers who provide worksites have valued, long term, reliable employees. One of the greatest benefits to employers is that supported workers have very low turnover rates, which significantly reduce employer recruiting, hiring and training costs.

II. State Plan Requirements

* States are not required to produce and submit a separate state plan in order to receive supported work funding. Instead, the supported work program requires only that the state prepare a "supplement" to the Title I VR services state plan (29 U.S.C. Section 795m(a)(l); 34 C.F.R Section 363.10(a)).

* The supported work supplement requires the state to conduct a needs assessment for persons with severe handicaps, just as the Title I VR services program required a needs assessment for persons with handicaps (29 U.S.C. Section 795m(b)(2)(A)). Based on the needs assessment, the supplement must then describe the quality, scope and extent of services to be provided (Section 795m(b)(2)(B)).

* Describing the scope and extent of services to be offered is a complex task. Because supported work is dependent on other programs for extended services funding, there must be formal agreements with other agencies which will provide this funding. Maximum use must be made of services from other public and private agencies (Section 795m(b)(3)(F); (b)(4)).

* Specifically, these agreements must identify the agencies and organizations that will "collaborate" with the supported work program, 34 C.F.R. Section 363.ll(f), and state the amount of funding to be provided by the extended services providers, and an estimate of the number of persons to be served by these funds (34 C.F.R. Section 363.50). The agencies to be involved in both the short term and ongoing services must then be included in the individual's IWRP (34 C.F.R. Section 363.11(e)(2)).

* Another requirement is that the substance of these agreements must reach each supported work participant. The state must assure that before any applicant for vocational rehabilitation services is found to have no rehabilitation potential, and therefore be rejected for services, a supported work assessment will be conducted. The assessment must consider the applicant's need for supported work, as well as the training and "post-employment" services that will be required. Those services must be incorporated into an IWRP, and the training and other services provided to applicants be in accord with their IWRPs. There also must be periodic re-reviews of individual progress (29 U.S.C. Section 795m(b)(3)).

III. INDIVIDUAL ELIGIBILITY CRITERIA

A. Introduction

* The eligibility criteria for supported work are as liberal as those for the Title I VR services program. Supported work can be viewed as an extension of the Title I program: any person with a severe handicap, who is present in the state, and who can demonstrate a reasonable expectation that VR services will benefit his or her employability, including supported work, will be eligible for services.

1. Definition of Supported Work

* Supported work is defined in the Act and regulations as:

competitive work in integrated work settings

(A) for individuals with severe handicaps for whom competitive employment has not traditionally occurred, or

(B) for individuals for whom competitive employment has been interrupted or intermittent as a result of a severe disability, and who, because of their handicap, need on-going support services to perform

> such work. Such term includes transitional employment for individuals with chronic mental illness. For the purpose of this Act, supported employment as defined in this paragraph may be considered an acceptable outcome of employability (29 U.S.C. Section 706(18)).

* "Supported work" is clearly a term of art. Its definition in the regulations covers a full page of single spaced fine print. Five of the component terms of this definition are defined below.

2. Individual With Severe Handicap

* The key part of the definition is "individual with severe handicaps." This term is defined in the Act as

> an individual with handicaps, . . . (i) who has a severe physical or mental disability which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employability; (ii) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time . . .(29 U.S.C. Section 706(15)).

* An "individual with severe handicaps" has three principal differences from an "individual with handicaps," which is used in the Title I VR services program: greater limitations; more complex services needs; and a longer duration of services. The individual's "physical or mental condition" will impose greater limitations on employability (severe, as compared to material). The greater limitations imposed by the handicap will require multiple vocational rehabilitation services (no such prediction is made for individuals with handicaps). And, the multiple services will be needed for an extended period of time.

3. "Competitive Work"

* Competitive work is defined in the regulations as:

> work that is performed on a full-time basis or on a part-time basis, averaging at least 20 hours per week for each pay period, and for which an individual is compensated in accordance with the Fair Labor Standards Act (34 C.F.R. Section 363.7(a)(2)(i)).

4. "Integrated Work Setting"

* Integrated Work Settings are alternately defined in the regulations as job sites where:

(A)(1) Most co-workers are not handicapped; and
(2) individuals with handicaps are not part of a work group of other individuals with handicaps; or

(B)(1) Most co-workers are not handicapped; and
(2) individuals with handicaps are part of a small work group of not more than 8 individuals with handicaps; or

(C) If there are no co-workers, or the only co-workers are members of a small group of not more than 8 individuals, individuals with handicaps have regular contact with non-handicapped individuals, other than personnel providing support services, in the immediate work setting (34 C.F.R. Section 363.7).

a. Services Delivery Models

- These regulatory definitions translate into three principle service delivery models:

i) **Individual Placement & Employment Supports**: This model establishes employment opportunities for individuals with severe handicaps in local employers (industries, services, government) on a one person/one job basis. A trained employment specialist (job coach, defined below) develops the position, matches the individual to the job, trains the individual on the job, and provides on-going support to the individual and employer for as long as such services are required.

ii) **Enclave**: An enclave is a small group of not more than 8 persons with severe handicaps who work for a single employer and who receive training, supervision and on-going support provided by a community agency.

iii) **Mobile Crew**: A mobile crew of persons with severe handicaps who serve as work crews to many local businesses and/or government entities. The crews usually consist of five persons with a supervisor. They all are employed by a community agency.

5. Ongoing Support Services

- A person with severe handicaps who enters supported work will differ from other workers because s/he will require "on-going support services." These are to be distinguished from "traditionally time-limited post-employment services" provided as a service within the Title I VR program.

- Ongoing support services are defined as:

> continuous or periodic job skill training services provided at least twice monthly at the work site throughout the term of employment to enable the individual to perform the work. The term also includes other support services provided at or away from the work site, such as transportation, personal care services, and counseling to family members, if skill training services are also needed by, and provided to, that individual at the work

site (34 C.F.R. Section 363.7(a)(iii)).

* The specific ongoing support services to be provided by the state VR agency, and by the interagency agreements for extended services must be included in the state plan supplement. The regulatory definition makes no mention of which source of funding will be responsible for these services in the short, middle, or long term.

* The services that appear on the VR services agency list and on the list for extended services, will in large measure determine the individuals with severe handicaps who will benefit from (i.e., participate in) supported work in that state. If a service needed by a particular individual is not included in the state plan supplement, the individual may not be able to take advantage of the supported work program.

a. Traditionally Time-Limited Post-Employment Services

* Traditionally Time-Limited Post-Employment Services are available to any individual who receives vocational rehabilitation through the Title I VR services program. These services are defined as part of that program as services "necessary to maintain or regain other suitable employment" (34 C.F.R. Section 361.41(a)(13)).

* As part of the supported work program, the definition has an added criterion: that the services be provided for a period not to exceed 18 months. At that time, a transition will be required to extended services provided through a cooperative agreement with another funding source.

6. Transitional Employment For Individuals With Chronic Mental Illness

* As noted above, supported work was created to provide training and employment opportunities to persons who have not traditionally been employed, or whose employment has been interrupted or intermittent as a result of severe handicaps (34 C.F.R. Section 363.7(a)(1)(i)(A);(B)). Another characteristic of these individuals (and which may in part explain their poor employment histories) is that they were excluded from the Title I VR services program.

* Historically, one group of individuals with handicaps who have this type of past-employment profile, and who have been excluded from the Title I VR services program, is individuals with chronic mental illness. To remedy this practice, the supported work program expressly includes persons with chronic mental illness, and describes an employment program in which they may be able to benefit.

* Transitional employment for individuals with chronic mental illness is defined as:

> competitive work in an integrated work setting for individuals with chronic mental illness who may need support services (but not necessarily job skill training services) provided either at the work site or away from the work

site to perform the work. The job placement may not necessarily be a permanent employment outcome for the individual.

* Transitional employment may be of benefit to persons who are about to re-enter the work force after a period of impairment related unemployment. The employment may be less than full time; it also may enable the individual to work at a setting that is less stressful than the job the individual previously held. The final sentence of the definition, mentioning that the placement need not be a "permanent employment outcome" means that the person does not have to use the supported work program to immediately regain his or her former position.

IV. Supported Work Services

* There are four principal supported work services, funded by two sources. Three are funded by the Rehabilitation Act, and for one, the funding must be provided by other sources. The supported work services funded under the Rehabilitation Act include:

A. Evaluation of Rehabilitation Potential

* Applicants for all vocational rehabilitation services must be evaluated to determine the nature and scope of their handicaps, as well as their rehabilitation potential. For persons who may be placed in supported work, an evaluation is most likely to be conducted as part of the Title I program, and will result in a finding that the person is not capable of unassisted competitive employment. Rather than be rejected for services, however, the person must then receive a separate evaluation to determine his/her potential for supported work.

* The supported work evaluation must determine whether the person is reasonably likely to benefit from a supported work placement, and if so, it must also identify the types of services the person will require. The services assessment must include both those for which funding will be provided by the Rehabilitation Act, and the "extended services" the person will require (34 C.F.R. Section 363.4(a)).

B. Job Development & Placement

* Job development and placement is likely to involve both the state VR agency "rehabilitation counselor" as well as an individual employed in the role of employment training specialist, more commonly known as a "job coach." Both persons may share responsibility to work with potential supported work employers and with the person with severe handicaps to develop the supported work job, and to arrange job placement.

C. Traditionally Time Limited Post Employment Services

* Among the services that may be provided to persons in supported work positions include:

intensive on-the-job training and other training provided by skilled job trainers (job coaches);

follow-up services, including regular contact with employers, trainees with severe handicaps, parents, guardians or other representatives of trainees, and other suitable professional and informed advisors in order to reinforce and stabilize the job placement, and;

regular observations or supervision of individuals with severe handicaps at the worksite.

D. Extended Services

- The post employment services described above may carry over beyond the 18 month coverage limit set forth in the Rehabilitation Act. At that time limit, these services become part of the array of "extended services" provided to the person with severe handicaps, and must be funded by other sources.

- The most likely sources of extended services funding are the state mental retardation and developmental disabilities agency, and the state mental health agency, to pay for the services required by persons with those conditions. For persons with neither of these conditions, the long term funding source may not be so easily identified. In addition, persons with health care or medical needs, may seek services funding through the state Medicaid program, other public benefits, or private insurance.

E. Job Coach

- The job coach is an essential element of the supported work program. The job coach is the equivalent of an "employment case manager" for a person with severe handicaps who is participating in supported work activities. The job coach is likely to be a part of all services provided to the person engaged in supported work activities, including those provided directly to the person with severe handicaps, and those that benefit the person indirectly, such as through contacts with the employer, other services providers, and as necessary, the person's family.

1. Job Find

- Long before a person with severe handicaps begins a supported work position, a job coach is likely to be surveying the community, looking to identify potential supported worksites. Industrial sites, services providers, restaurants, and government offices are all potential places of supported employment. For example, a very short list of supported work jobs currently being filled includes the following:

medical statistician for hospital;

file clerk in banks and other businesses;

telephone sales clerks;

maintenance workers;

food preparation workers; computer data entry clerks.

2. Task Analysis & Job Placement

- Once potential worksites are identified, the job coach must then undertake a process of job or "task analysis." This requires each of the activities that comprise the job to be broken down into separate components. Then, the job coach must identify both the cognitive, physical, time, and other performance demands of each task.

- As part of the job development process, the job coach will have to work with the employer to adapt the job's activities, or perhaps its physical setting, or both, to enable as many as possible of the job's individual tasks to be completed by the person with severe handicaps. The specific task and physical modifications will be negotiated when a supported work candidate is being matched with a particular employer and a particular job.

- The Rehabilitation Act states that supported work services are to be considered "complementary" to the services provded under Title I (29 U.S.C. Section 795n(c)). Based on this provision, persons with severe handicaps should have available all the rehabilitation engineering, and assistive technology devices and services that are required to make a supported work placement a success. Alternately, these services can be provided by the employer, or by other sources of funding, such as Medicaid, or private insurance. A recent survey of UCPA affiliates which provide supported work employment reported that 40% of the persons in supported work positions utilized rehabilitation technology in one form or another.

3. Worker Training, Supervision & Support

- The job coach will next be responsible for ensuring the person with severe handicaps is capable of performing the job. The job coach will provide training and initial supervision to the worker both out of the worksite, if needed (such as the development of appropriate social skills; transportation skills; etc.) and at the worksite (social integration and work related skills).

- The underlying premise is that the job coach will be able to reduce his/her services to the worker as the worker becomes more familiar with the job demands and routines.

- The job coach's duties as a trainer/supervisor may require more than the 18 months permitted by the Rehabilitation Act for the provision of "post employment services." If so, the job coach will then have to be funded by the "extended services" funding source.

- Supported work contemplates that the worker will require continuing follow along services for the life of the job. These services may be provided by the job coach, or at some point they may be assumed by the employer as part of the supervision the employer provides to all workers.

4. Worksite Health/Medical Services

- Among the persons with severe handicaps who may be capable of supported work placements are persons with health or medical care needs. A simple example is a person who requires toileting assistance during the day.

- Although the assistance required is not difficult to provide, it is also not difficult to foresee problems in the identification of the source of the assistance. Does the job coach help? Is the employer expected to designate a co-worker, plant/facility nurse or aide, or supervisor to help? Or, should another service provider be responsible, and if so, which one?

- For many persons participating in supported work, one of the "other service providers" will be Medicaid. Can Medicaid be asked to pay for an aide to provide worksite based health care? Unfortunately, the answer is not clear. Medicaid has stated that "home health aides," the service that would provide comparable assistance to a person at home, cannot provide services in settings other than the person's home. In addition, most insurance policies set limits on the number of home health services that will be covered in a calendar year that are insufficient to address worksite health care needs.

- At present, the Medicaid "at home only" restriction for home health aides has been set aside in a number of individual cases in New York, but none of these cases have involved persons who sought to have their aides provide services in a workplace. However, no reason exists for these decisions not to be applicable to worksites.

- A lawsuit that seeks to comprehensively address the problem of "at home only" restrictions on Medicaid home health services (including home health aides, LPNs, RNs, and therapy providers) is now pending in the federal district court in Connecticut. *Skubel v. Sullivan* is a proposed nationwide class action which seeks to eliminate all "at home only" restrictions on Medicaid home health services. Like Medicaid private duty nursing services, addressed in the *Detsel* and *Pullen* litigation, *Skubel* seeks a court determination that these services are "setting independent," thereby eliminating the potential problem for supported workers who have worksite health care needs.

5. Community Services Assistance

- Another job coach responsibility is to assist the person with severe handicaps, and the person's family, as necessary, to secure the support services from other community providers that are needed to make the supported work setting successful. Often this involves transportation, but it may also include securing home health services, medical services, home modifications, etc.

V. What Makes Supported Work An Assistive Technology Resource?

A. Introduction

* Supported work is an extremely important opportunity for persons with severe handicaps, a group which most definitely includes persons who will require assistive technology devices and services in order to participate in the workplace. It also is true that there will be a broad continuum of both cost and sophistication of the assistive technology that will be required by persons participating in supported work.

B. General Program Criteria Supporting Funding

* Because supported work is required to be a collaborative effort among many agencies and programs, it should be viewed as offering the most complete array of funding possibilities for assistive technology. Supported work will be a success only if states make the commitment to ensure participants will have access to all the services, including assistive technology devices and services, they may require. The broad coverage rules governing all the other programs discussed in this manual should be made applicable to supported work candidates, thereby making available all types of assistive technology. Supported employment funds can also be used for purchase of assistive technology devices and services.

C. General Program Criteria Perceived As Funding Barriers

* There are no express assistive technology funding barriers in the Rehabilitation Act supported work provisions or in the accompanying regulations.

* The supported work program does have some potential barriers to its ability to reach its full potential as an employment program for persons with severe handicaps, including persons who will require assistive technology. These barriers include:

Medicaid Restrictions

Conflicts of Interest
Among Services Providers

Lack of Funding

Lack of Basic Knowledge

Each of these potential barriers is described below.

1. Medicaid Services Restrictions

a. "At Home Only" Restrictions

* Already discussed in this section are the potential barriers created by "at home only" restrictions in the Medicaid program that impact persons who require health care or medical assistance during the workday. Among them are those whose assistance is related to assistive technology.

b. Day Treatment Restrictions

- A second Medicaid barrier arises from restrictions on the use of "day treatment" funds. Many persons who would be successful in supported work positions presently are in day treatment or day activity programs funded by Medicaid. Unfortunately, the federal Medicaid program administrator, the Health Care Finance Administration (HCFA) has continually refused to allow Medicaid funds to be used for any vocational or even pre-vocational services.

- The effect of this exclusion is a waste of both the lives of persons in day treatment, and of a meaningful percentage of the more than $100 million/year of day treatment funds that could be far better spent for the "extended services" costs for supported employment. In addition, because persons in day treatment are considered "served," the state supported work program is steered away from addressing the needs of the persons who have the most severe handicaps.

2. Conflicts Of Interest Among Services Providers

- Persons who are potential candidates for supported work are likely to currently be at home, with no programs, in day treatment programs, or in sheltered workshops. Sheltered workshops are funded by the federal and state governments as a "transitional" vocational rehabilitation setting, a place where skills can be developed and later applied in the competitive economy. But for many persons, sheltered employment is a permanent, dead-end placement, where workers are paid "pennies", rather than real wages.

- Supported work was designed in part to remove persons from sheltered workshops and to give them opportunities to participate in real jobs. Unfortunately, many states have given supported work responsibilities -- such as job development and placement, and employment of job coaches -- to the same community agencies that operate sheltered workshops. This creates an obvious financial conflict of interest.

- Here again, the barrier is created by unresponsive funding rules. Sheltered workshops receive greater per worker funding than does supported work. Sheltered workshops also receive funding for as long as a worker is there, unlike the 18 months of post employment funding through supported work, and the possibly limited funds available for extended services. Sheltered workshops also receive compensation through the production contracts that workers fulfill.

- Viewed as a whole, these three financial conflicts create disincentives for sheltered workshops to allow their most productive employees to enter supported work. Likewise, if extended services funding is limited, sheltered workshops have a strong disincentive to place in supported work positions persons who will require a significant degree of permanent worksite services, based on the foreseeable lack of future funds for extended services. This may be particularly true for workers who require assistive technology services, such as medical care.

- State Tech Act staff should be careful to identify the interrelationships among the supported work services providers. It may be appropriate to request the state Attorney General to investigate whether sheltered workshops ties to the supported work program violate state rules regarding the fiduciary duty of not-for-profit corporations toward the persons they serve.

3. Lack of Funding for Supported Work

- Like Title I VR services program, the size of the supported work program does not necessarily bear any relation to the number of persons in the state who may be able to benefit from the program. These programs are able to limit services based on the size of the funds appropriated, and when it appears the funding will be inadequate, "orders of selection" can be implemented.

- For supported work, funding will be limited at two points. First, the funds available through the supported work program are extremely small. This will limit the opportunity for persons to get involved in the program. Second, the opportunity for persons to continue in the program will be limited by the extent and scope of the "extended services" interagency agreements.

- For example, in New York, there are financial caps (limits) on the amount of funding available to persons in supported work, in both the initial and extended services phases of the program. No explanation has yet been given to what will happen to individuals when the funding runs out.

- It is likely to expect that these funding limits will cause persons with the most severe handicaps to be excluded from supported work. Cost, rather than ability factors are likely to control placement decisions: for persons whose initial costs may be high, and who will require long term services that extend beyond the extended services limits, there may be no effort to develop a supported work placement. "Why bother," or "why invest the funds if the return will be temporary" are foreseeable responses. The persons with severe handicaps will simply be left in their day program, sheltered workshop, or at home.

- State Tech Act staff can ensure this does not happen by seeking a strong policy commitment to supported work within the various participants in the state government. They may seek to work with the state legislature to provide additional funds for extended services, and to eliminate "caps" on services. If further research is needed prior to the commitment of state financial resources, Tech Act staff may sponsor or seek sponsors for evaluations of supported work programs to determine whether, like VR services, there are net financial gains to the state that supports these efforts. State Tech Act staff must become involved in policy development in regard to this program. Tech Act staff also can take the initiative in seeking non-public funding. For example, persuading supported work employers assume the costs of services, or to seek "projects with industry" grants, which may provide sufficient funding for "post" extended services costs.

a. Supplemental Security Income Barriers

* A frequent, yet wholly unnecessary and unlawful barrier to persons with severe handicaps who engage in supported work is the threat that their Supplemental Security Income (SSI) disability benefits will be denied or terminated as a result of their participation in supported work. Many persons with severe handicaps who may be candidates for, or participants in supported work are applicants for or recipients of Supplemental Security Income (SSI). SSI is a federal "welfare" benefit provided to persons who meet a federal definition of "disability."

* As a welfare benefit, a person's entitlement to SSI is based on his/her income and resources. This means that as a person's income increases, the amount of the SSI benefit will decrease according to a formula set forth in the SSI rules. If income increases above a certain level, the person's SSI benefit can become zero.

* The problem for supported work is that SSI also looks at the person's income in relation to his/her ability to work, in addition to simply being an offset to the SSI amount. Because workers in supported work are often paid the minimum wage or more, their income may approach or exceed the monthly sum the SSI rules apply to find a person "able" to work, and therefore "not disabled."

* The intersection of supported work and the SSI finding of "able to work/not disabled" occurs frequently. It may result in a notice of denial or termination of SSI benefits. Despite their frequency, these notices should not be issued. Income from supported work can legitimately be an offset of SSI benefits, but should not result in a decision that the person is able to work or not disabled.

* Stated most simply, supported work income is "subsidized" according to the SSI rules. Therefore, special rules must be applied before a determination of "ability" to work is made. Subsidized income is not counted as income equivalent to that earned by a person with no handicaps. If a person earns a dollar, but receives the equivalent to a 50 cents subsidy, the person's "ability" to earn is only 50 cents. If the person's total wages are $600 per month in supported work, for SSI's purposes, his/her real "ability" to earn is only $300. Although the former total would be higher than the SSI sum used to determine a person is "able" to work and not disabled, the latter total is significantly below that sum. Thus, as a result of the supported work subsidy, the person would be able to continue on SSI.

* Also, many persons who participate in supported work live in supported living environments, which are paid for from a combination of the person's earnings and SSI benefits. These "costs" are called "impairment related work expenses" ("IRWE's"), and also reduce the amount of "income" earned through supported employment. IRWEs will affect both the amount of the SSI benefit, and the "ability to work" determination.

- First, a person with IRWEs can subtract the cost of the IRWE from his/her monthly income before their SSI benefits rate is calculated. For example a person with a monthly supported work income of $400, with a $150 IRWE for supported living services, will have an income for SSI purposes of $250. The effect of the IRWE is to reduce the person's monthly income, and increase his/her potential SSI payment.

- Second, IRWEs also are part of the determination of "ability to work." IRWEs are simply a different form of subsidy. A person who can earn $600 monthly, but has IRWE's of $150 has the "ability" to earn only $450 per month. As in the example listed above, the former sum is greater than the SSI sum used to determine a person is "able" to work and not disabled, but the latter total is below that sum. Thus, as a result of the IRWE the person would be able to continue on SSI.

- State Tech Act staff can help reduce the confusion and unlawful practices employed by the Social Security Administration in two ways. First, it can directly intervene with the state agency which makes the first two levels of administrative decisions under the SSI programs. The agencies have many names, but are commonly called "disabilty determination services," ("DDS"). A call to any Legal Services office will get the correct agency name in the state. The Tech Act staff can inquire whether the state DDS is aware of the special rules applicable to subsidized income and IRWE's, and whether it has the latest policy statements from the Social Security Administration directly applicable to supported employment.

- State Tech Act staff also may seek an interagency agreement between the state VR agency and the DDS, or an executive order from the Governor, to commit the agency to apply the subsidized earnings and IRWE rules prior to issuing decisions for persons engaged in supported work.

- In addition, state Tech Act staff also may organize and direct a widespread education program in the state -- to supported work services agencies, to state VR services program staff, to the DDS staff, to Legal Services, Client Assistance Program, Protection & Advocacy staff, and others, to ensure that no person is wrongfully denied or terminated from the SSI roles. In some states, (e.g., New York, Pennsylvania, Illinois) the state government pays advocates to represent persons seeking to secure or retain SSI benefits because it results in significant savings of state public assistance or welfare funds. Yet many of these advocates may not be aware of supported work, or of the subsidies and IRWEs that accompany it.

4. Lack of Basic Knowledge

- The techniques and assistive technologies for rehabilitation of persons with handicaps continue to evolve rapidly. The pace of these changes, however, is likely to be much greater than the rate at which they are acknowledged and applied by decision makers. This creates a "lack of basic knowledge" that is likely to be particularly acute for persons with severe impairments who will benefit from supported work. It is reasonable to estimate that the gap between the development of suitable rehabilitation techniques and technology and the frequency of their application will be greatest for persons with the most severe impairments. For this reason, persons who with severe handicaps face significant barriers to being given the opportunity to participate in, and to benefit from supported work programs.

* To reduce knowledge gaps, and to increase the rehabilitation services options available to persons with severe impairments, state Tech Act staff can play many roles. For example, Tech Act staff may consider serving as a clearinghouse to the state rehabilitation services agency for assistive technology research and information; providing or sponsoring in-service trainings for rehabilitation services decision makers; and highlighting model supported work programs. Information can be developed through UCPA and other organizations taking a leadership role in supported work, research journals, rehabilitation counselor education programs at higher education institutions, etc.

Part D. Comprehensive Services For Independent Living

I. Introduction

* Comprehensive services for independent living ("independent living services") is a very small formula grants program available to the states to assist persons with the most severe handicaps. ($13 million appropriated for distribution in FY 89). The program also is known as "Title VII" or "Part A." It is found in the Rehabilitation Act at 29 U.S.C. Section 796-796d; and at 34 C.F.R. Part 365.

* The independent living program serves persons at the farthest end of the impairment continuum, beyond persons who are eligible for either Title I VR services or supported work. In creating the independent living services program, Congress recognized that some persons simply have no potential for employment, but may nonetheless benefit from vocational rehabilitation services aimed at allowing them to live more independently. Thus, instead of "employability" as a key goal, the operative concept for this program is "enhanced independent living" (29 U.S.C. Section 796).

* The independent living program can be viewed as the broadest of all the vocational rehabilitation programs. Its services incorporate all the Title I VR services, and then adds others. Its promise is to promote community integration of persons with the most severe impairments, which may mean community based living as an alternative to institutionalization, as well as increased independence for persons living at home.

* Perhaps the most important characteristic to remember about the independent living services program is its potential: its purposes are broad and extraordinarily important. At the same time, attention must be directed to the efforts necessary for independent living to realize its potential, including interagency coordination and adequate funding. State Tech Act staff can serve an important role by working with the state vocational rehabilitation services agency to ensure the state independent living program provides comprehensive services, and uses its very limited funds in the most cost effective manner

possible.

II. State Plan Requirements

- To receive funding under the independent living services program, states must submit a three year state plan that meets the criteria set forth in the Rehabilitation Act, 29 U.S.C. Section 796d, and the federal regulations, 34 C.F.R. Section 365.2 - 365.16.

- The independent living services plan can either be submitted separately, or be part of a "consolidated rehabilitation plan," which combines the state plans required by the Title I program, and/or the Developmental Disabilities Assistance & Bill of Rights Act (34 C.F.R. Section 365.2(c)).

- The state plan must be based on a needs assessment conducted by the state that identifies the types of services that are needed as part of the independent living program. The needs assessment must include services that the state proposes to provide that will "to the maximum extent feasible," provide "meaningful alternatives to institutionalization" (29 U.S.C. Section 796d(a)(2); 34 C.F.R. Section 365.8).

- The state plan must explain the scope and extent of services that will comprise the independent living services program, based on the needs assessment and other information available to the state (29 U.S.C. Section 796d(a)(3)(A)).

- The Rehabilitation Act requires the states to provide assurances that each person receiving independent living services receives an IWRP, and that the services provided are in accord with those listed on the IWRP. In addition, the Act demands that the state coordinate independent living services with those provided by other programs, and which appear in the person's "individual habilitation plan," ("IHP"), or "individualized education program" (IEP) (29 U.S.C. Section 796d(a)(4)). The state also must provide assurances that it will conduct periodic reviews of each person's IWRP in the independent living services program (Section 796d(a)(6)).

- The state plan must explain the cooperative agreements made by the state with other programs, both public and private, that provide benefits and services to persons receiving independent living services (34 C.F.R. Section 365.11 - 365.12).

- Finally, the state plan must state the "order of selection" that will be followed in selecting persons who are to be eligible to receive independent living services. The order of selection is needed to establish priorities among persons who meet the general criteria for eligibility, because there are insufficient funds in the program to meet all their needs (34 C.F.R. Section 365.34).

- The regulations require the order of selection to enable persons with the most severe handicaps to be served first. This must include homebound individuals, persons not being served by the Title I VR services program, persons who are institutionalized, and persons who are at risk of becoming institutionalized.

III. Individual Eligibility Criteria

- The Rehabilitation Act defines eligibility for the independent living services program in part by making a comparison to the eligibility criteria applicable to the Title I VR services program:

> services may be provided under this title to any individual whose ability to engage or continue in employment, or whose ability to function independently in the family or community, is so limited by the severity of the disability that vocational or comprehensive rehabilitation services that are appreciably more costly and that are of appreciably greater duration than those vocational or comprehensive rehabilitation services required for the rehabilitation of an individual with handicaps are required to improve significantly either the ability to engage in employment or the ability to function independently in the family or community. Priority of services under this part shall be given to individuals not serviced by other provisions of this Act (29 U.S.C. Section 796a(a)).

- The federal regulations translate this statement of eligibility into three general criteria:

A. Person With A Severe Physical Or Mental Disability

- This term appears to be a composite of two definitions: "physical or mental disability" found in the Title I VR services regulations, and "individual with severe handicaps" found in the independent living services regulations.

1. Physical or Mental Disability

- The Title I regulations define "physical or mental disability in the broadest of terms:

> a physical or mental condition which materially limits, contributes to limiting, or if not corrected, will probably result in limiting an individual's employment activities or vocational functioning (34 C.F.R. Section 361.1).

2. Individual with Severe Handicaps

- The independent living services regulations define "individual with severe handicaps" as follows:

> an individual whose ability to function independently in family or community, or whose ability to engage or continue in employment is so limited by the severity of his or her physical or mental disability that it has been determined that independent living rehabilitation services are required in order to enable

achieving a greater level of independence in functioning in family or community or engaging or continuing in employment (34 C.F.R. Section 365.1(b)).

B. Severe Limitation of Independent Functioning

* The second eligibility criterion for independent living services is as follows:

> The presence of a severe limitation in ability to function independently in family or community or to engage or continue in employment (34 C.F.R. Section 365.31(b)(2)).

C. Ability to Benefit from Independent Living Services

* The third eligibility criterion for independent living services is stated as follows:

> A reasonable expectation that independent living rehabilitation services will significantly assist the individual to improve his or her ability to function independently in family or community or to engage or continue in employment (34 C.F.R. Section 365.31(b)(3)).

* The regulations state further what is intended with regard to "improvement in ability to function independently in family or community." Such improvement should be capable of being measured in functional and behavioral terms, looking at either improvements in independence or maintenance of independence (against possible losses) in any of the following areas:

self care;

activities of daily living;

driving;

using public transportation;

shopping;

housekeeping;

communicating;

living more independently (34 C.F.R. Section 365.31(b)(3)).

* Determinations of whether a person with severe handicaps meets these criteria must be based on an evaluation (34 C.F.R. Section 365.32). As part of the evaluation process, a determination must be made whether the person is eligible, and if so, for which services. Each state is able to define the specific objective data are to be considered in the evaluation.

* Based on these extremely broad eligibility criteria, it is hard to imagine the impairments of a person who would not be able to benefit from independent living services. Some persons, though, may be denied services, allegedly because they cannot "benefit." But the regulations require that any such ineligibility decision be reviewed no

later than 12 months after the original decision was made (34 C.F.R. Section 365.33(b)(3); 365.36(d)).

* To reach its full potential, state independent living programs must be capable of providing the services these individuals require. The state needs assessment which is part of the state plan requirement, but be used to define the services that comprise the independent living program. State Tech Act staff can work cooperatively with the state vocational rehabilitation services agency to ensure that the state does not restrict the independent living program in ways that will exclude needed services, or restrict funding in ways that will exclude otherwise eligible individuals.

* State Tech Act staff also must make a careful review of the order of selection in the state plan. The order of selection should be avoided, if possible, by having adequate funding be available to the independent living program. If those funds are not available, the order of selection must assure that limited services are provided to those persons who are most in need: including persons who are homebound, institutionalized, or at risk of institutionalization (34 C.F.R. Section 365.34).

IV. Covered Independent Living Services

A. Introduction

* The list of possible independent living services is extremely broad. The Rehabilitation Act lists 12 services that may be funded, many of which are broad categories of services with many components. The federal regulations set forth an even more comprehensive list of services that are available for federal reimbursement. In addition, all the services in the Title I VR services program that may be of benefit to a person eligible for independent living services have been incorporated.

* However, none of the listed services is a mandatory component of a state's independent living program. The states are free to include only some or all of the services in their independent living program. Obviously, the more complete the list, the closer the program will be to reaching its full potential. Equally true is that a person who requires a service that is not selected as part of the state's independent living program will not be able to claim that service as an entitlement.

B. Covered Services

* The Rehabilitation Act states that the term "comprehensive services for independent living" includes:

> any appropriate vocational rehabilitation service (from the Title I VR services program) and any other service that will enhance the ability of an individual with handicaps to live independently and function within the family and community and, if appropriate, secure and maintain appropriate employment (29 U.S.C. Section 796a(b)).

- The Act then lists 12 services that may be included in the state independent living services program:

counseling services, including psychological, psycho-therapeutic, and therapeutic treatment;

housing incidental to the purpose of this section (including home modifications);

job placement services;

transportation;

attendant care (defined in the regulations at Section 365.(c)(3);

physical rehabilitation services;

related services;

needed prostheses and other appliances and devices;

health maintenance;

recreational services;

services for children of preschool age, including physical therapy, development of language and communication skills, and child development skills;

preventive services to decrease the needs of individuals for similar services in the future (29 U.S.C. Section 796a(b)).

- The federal regulations expand upon this list to increase the number and scope of services available under the program:

counseling services is expanded to include peer counseling and advocacy services;

physical & mental restoration services are added, which include:

physical and mental medical rehabilitation services; dentistry services; nursing services; therapeutic treatment, such as PT, OT, speech, language and hearing therapy, therapeutic recreation, drama therapy, music therapy, and art therapy; health maintenance; eyeglasses and visual services; prosthetic, orthotic & other assistive appliances and devices;

reading services, rehabilitation teaching services and orientation & mobility services for blind individuals, were added;

interpreter services for deaf individuals, including tactile interpretation for deaf-blind individuals were added;

vocational and other training services, including personal and vocational adjustment, were added;

referral services were added;

telecommunications, sensory & other technological aids and devices were added;

services to family members if necessary for improving the individual's ability to live and function more independently, or the individual's ability to engage or continue in employment, were added;34 C.F.R. Section 365.37(a).

* Because the Rehabilitation Act and regulations do not set forth a list of services that are mandatory components of the independent living program, state programs that voluntarily include more of these services will be broader, and more capable than those that choose to include fewer services. It is possible that states will not include all the types of services that are needed by persons who may benefit from independent living services. The challenge to state Tech Act staff and state vocational rehabilitation services staff is to convince state governors and legislators that these services must be included, and sufficient funding provided.

* The selection of services to be included in the state plan does have one important limitation. The federal independent living regulations expressly require the state plan to assure that

> no group of individuals is excluded from service solely on the basis of the type of disability or on the basis of age (34 C.F.R. Section 365.31(a)).

This rule makes it important for states to explain the basis for their decisions whether to include or exclude a specific service in their state independent living plans, particularly when the service has been identified as being needed by some persons in the state independent living needs assessment.

V. Are Independent Living Services An Assistive Technology Resource?

* The independent living services program should be seen as a vast resource for assistive technology. The list of covered services includes many that will support funding for assistive technology. These services are discussed in the Title I VR services section of the funding manual and the presentations are not repeated here.

* In addition, many of the services that may be considered part of the state's independent living services program may be covered services under another funding program, such as Medicaid, the EHA, developmental disabilities services, etc. Some of these programs are discussed in this funding manual as assistive technology funding resources. Through the state plan requirement of "interagency agreements," the resources of these public funding programs should be available sources of independent living services as well.

* State Tech Act staff, along with the staff of the vocational rehabilitation services agency must review all these programs, and create the necessary interagency agreements to comprehensively determine how to secure the maximum independent living benefits from the limited funding available from each one.

* For example, there is a substantial overlap between the independent living goals of the Title I VR services program, Medicaid and the independent living program under the Rehabilitation Act. Yet the amount of funding available under each program is very different. Because of the overlaps and funding disparities, states must make careful

decisions as to which program should be responsible for providing which service.

- Despite the 90 percent federal reimbursement rate, 29 U.S.C. Section 796c(b), a state must make difficult decisions about expending the extremely scarce independent living funds instead of far more plentiful Title I or Medicaid funds, particularly for potentially expensive assistive technology. By making these decisions carefully, and with a comprehensive view toward funding, the limited direct funding for independent living may be "stretched" to reach a broader number of services, and a greater number of individuals. Despite the limited Title VII funding, state Tech Act staff should still encourage expenditures for the delivery of assistive technology services or at the very least advocacy and counseling on technology funding and device choices.

- In addition to Part A, Title VII includes Parts B and C, Centers For Independent Living. The Centers For Independent Living (CIL) Program under Part B was established in 1978. Nonprofit agencies nationwide compete for funds by submitting applications to the Rehabilitation Services Administration. In Fiscal Year 1991, there are 146 federally funded projects in 196 locations across the country. It is estimated that 40,000 individuals annually receive services from CILs. Centers are authorized to provide a broad array of services to develop the advocacy skills of persons with severe disabilities, to provide peer counseling and to provide training to develop independent living skills. A growing number of CILs are directing resources to improve awareness, access, and training regarding assistive technology devices and services. It is a challenge to Tech Act lead agency staff to involve directors and staff of CILs in the planning and development of a "statewide consumer-responsive" system of technology-related assistance.

- Unlike Part B which authorizes Centers For Independent Living for individuals across disabilities, Part C provides funding for independent living services for older blind individuals. First funded in 1987, grants are provided to designated state units which may then make subgrants to provide services. Services which may be provided include: low vision aids, mobility training, reader services, and other appropriate supportive services to assist older persons who are blind to live independently. There are 28 states now receiving funding under Part C with the average grant size being less than $200,000.

- The states currently funded under Part C are:

Alabama
Arizona
Arkansas
Colorado
Hawaii
Idaho
Illinois
Indiana
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
New Hampshire
New Jersey
New York
North Carolina
Oregon
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Vermont
Virginia
Washington
Wisconsin

- The National Council on Disability estimates that only one of every ten individual with disabilities will receive independent living services under Parts A, B, or C. Despite the limited funding, the authorization exists under all three parts to dedicate resources to increase understanding, access, and funding of assistive technology devices and services. Technology is a means to achieve independence and integration. Demonstration and training opportunities should be a part of your state's comprehensive independent living services program.